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ABSTRACT

The proceedings of a conference on women's leadership and authority in the health professions is presented. Following the opening remarks by Patricia Borne, speeches by Lucy Geiselman on the history of women in the health sciences and Sheryl Ruzek on the purpose of the conference are presented. The keynote address by Norma Juliet Wikler on the status of women in the health professions is provided. The following seven topics (and representative speech titles) are considered: (1) the informal organization of leadership and authority ("Development of Feminist Networks in the Health Sciences"--Arlene Kaplan Daniels): (2) further barriers to moving up ("Go Hire Yourself a Mentor"--Mary P. Rowe"; (3) career patterns ("Continuity and Noncontinuity in the Careers of a Sample of Young Women Physicians"--Lillian Kaufman Cartwright): (4) abstracts of published works and works in progress ("Becoming Professional"--Rue Bucher and Joan G. Stelling): (5) different structures of leadership authority ("Women in Decision Making"--Suzanne Estler): (6) innovative programs ("Reduced-Schedule Graduate Medical Education: A Status Report"--Eileen Shapiro and Shirley G. Driscoll); and (7) directions for change ("Androgynous Maturity and the Nurse Practitioner"--Martha Sturm White). An approximately 150-item bibliography, a list of conference participants, and summary evaluation are appended. (PHR)

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ED180293

Women's Leadership & Authority in the Health Professions

proceedings of a conference at UC Santa Cruz
June 19-21, 1977

U.S. DEPARTMENT OF HEALTH,
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the program for Women in health sciences

University of California, San Francisco
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HE 011 951

PROCEEDINGS OF THE CONFERENCE ON WOMEN'S LEADERSHIP AND AUTHORITY IN THE HEALTH PROFESSIONS

SPONSORED BY THE PROGRAM FOR WOMEN IN HEALTH SCIENCES
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

LUCY ANN GEISELMAN, Ph.D.
Assistant Vice Chancellor, Continuing Education and Public Programs
Project Director

Held at Oakes College, University of California

Santa Cruz, California
June 19-21, 1977

CONFERENCE CONVENORS

PATRICIA BOURNE, Ph.D.
Assistant Professor of
Community Studies and Sociology
Oakes College
University of California, Santa Cruz

SHERYL RUZEK, Ph.D.
Community Coordinator
Program for Women in Health Sciences
University of California, San Francisco

This conference was supported by Contract # HRA 230-76-0269

DEPARTMENT OF HEALTH EDUCATION AND WELFARE

HEALTH RESOURCES ADMINISTRATION
OFFICE OF HEALTH RESOURCES OPPORTUNITY

CLAY E. SIMPSON, JR. Ph.D., CHIEF
CLAIRE B. MANSBERG, PROJECT OFFICER

ACKNOWLEDGEMENTS

This conference and Proceedings are the result of many people's work. We especially wish to acknowledge the contributions of the following individuals whose dedication, commitment and cooperation made this event and this collection of working papers possible.

Dr. MARTHA WHITE and Dr. LUCY ANN GEISELMAN, co-founders of the Program for Women in Health Sciences, University of California, San Francisco, initially conceived of the conference on women's leadership and authority in the health professions. Their continuing interest, support and guidance were both inspiring and invaluable.

Funds for the conference were provided by a contract (#HRA 230-76-0269) from the Office of Health Resources Opportunity, Health Resources Administration, U.S. Department of Health, Education and Welfare. Dr. MAGGIE MATTHEWS, former Assistant Director for Special Programs took personal interest in the project; her support is acknowledged and appreciated.

The staff of the Program for Women in Health Sciences deserve particular thanks for their dedicated efforts before, during, and after the conference. VELMA PARNESS, Program Manager, assumed responsibility for the myriad of arrangements required to put on the conference and collect the Proceedings material. Her work was complicated by the necessity of coordinating the staffs of several offices on two separate University of California campuses. She was assisted by GLEORIA BRADLEY-SAPP, Administrative Assistant, and VERENA FONG, Project Secretary, who handled housing and transportation arrangements and clerical services. JEAN BORN, Resource and Guidance Coordinator, was responsible for the conference literature display.

On the Santa Cruz campus, Conference Coordinator GORDON CRAFTS and Oakes College Bursar ROBERT LIM and their staffs managed the housing and conference arrangements. JOAN WARD handled the press coverage.

JO HARTLEY, Editor-Publisher of Comment --On Research About Wo/Men, assumed major responsibility for editing the working papers for the Proceedings. She is also preparing conference material for wider distribution to educators, researchers, and policy-makers concerned with women's roles in the professions.

Finally, the conference participants are to be commended for sharing their in-progress work and ideas in the spirit of cooperation and collective effort that so marked the conference. The openness and spontaneity of exchange made this conference particularly exciting and rewarding to us.

Sheryl Ruzek
Patricia Bourne
August 4, 1977

TABLE OF CONTENTS

I. CONFERENCE AGENDA 1

II. OPENING REMARKS 4

Welcome.....PATRICIA BOURNE 5
History of the Program for Women in Health Sciences.....LUCY ANN GEISELMAN. 6
Purpose of the Conference.....SHERYL RUZEK 8

III. KEYNOTE ADDRESS

Coming In and Moving Up: Women in the Health Professions
.....NORMA JULIET WIKLER 10

IV. THE INFORMAL ORGANIZATION OF LEADERSHIP AND AUTHORITY 23

Development of Feminist Networks in the Health Sciences
.....ARLENE KAPLAN DANIELS 24

Why Be a Role Model When You Can Be a Mentor?.....FLORENCE HASELTINE . . . 36

Go Hire Yourself a Mentor.....MARY P. ROWE 40

Reconceptualizing Leadership: Lower-Status Women and the Exercise
of Power in Health Care Settings.....VIRGINIA OLESEN 43

V. FURTHER BARRIERS TO MOVING UP 54

The Saturns Rings Phenomenon: Micro-Inequities and Unequal
Opportunity in the American Economy.....MARY P. ROWE 55

Some Thoughts on Counselling Women who Perceive Themselves
To Be Victims of Nonactionable Sex Discrimination: A
Survival Guide.....EILEEN SHAPIRO 73

Four Case Studies of Sex Discrimination Complaints and
Interventions.....JOANNE A. LEWIS 86

"You Can't Use It, But Don't Lose It", Sex in Medical
School.....PATRICIA GERALD BOURNE 91

Some Interactional Issues Concerning Women's Place in the
Health Professions.....CANDACE WEST 105

VI. CAREER PATTERNS: CHOICE AND CHANNELING 123

Career Patterns of Women in Medicine.....MARJORIE P. WILSON
and AMBER B. JONES 124

Continuity and Noncontinuity in the Careers of A Sample of
Young Women Physicians.....LILLIAN KAUFMAN CARTWRIGHT 146

Medical Immunity? Male Ideology and the Profession of
Medicine.....LYNNE R. DAVIDSON 157

VII. BROADENING THE PICTURE: OTHER ISSUES AND CONCERNS ABSTRACTS OF PUBLISHED WORK AND WORK IN PROGRESS 174

Vicarious and Direct Achievement Patterns: A Typology And Underlying Dynamics.....JEAN LIPMAN-BLUMEN and HAROLD J. LEAVITT. 175

Becoming Professional.....RUE BUCHER and JOAN G. STELLING 177

Women and Medical Sociology: Invisible Professionals and Ubiquitous Patients.....JUDITH LORBER 179

National Program to Advance Women in Higher Education Administration.....MARGARET B. WILKERSON 181

Nonverbal Communication and the Social Control of Women...NANCY M. HENLEY . 183

Women and Power: Toward a Theory of Effectiveness.....PAULA JOHNSON. . . . 185

Double Positive/Double Negative, Dilemma of the Minority Female Manager in Health and Elsewhere.....GLADYS HANDY 187

Doctors Wanted: No Women Need Apply.....MARY ROTH WALSH 189

Barriers to the Nurse Practitioner Movement: Problems of Women in a Woman's Field.....BONNIE BULLOUGH 191

The Political Process, Or, The Power and the Glory.....DONNA F. VER STEEG . 193

VIII. DIFFERENT STRUCTURES OF LEADERSHIP AND AUTHORITY 195

Women in Decision Making.....SUZANNE ESTLER 196

"Making Alot of Noise," Problems of Women's Leadership in a Participatory Democracy.....JANE J. MANSBRIDGE 218

IX. INNOVATIVE PROGRAMS 232

Reduced-Schedule Graduate Medical Education: A Status Report.....EILEEN SHAPIRO and SHIRLEY G. DRISCOLL 233

The Creative Leadership Training Program for Nurses: Viewpoint of a Student Who Became an Instructor.....JACQUELYNE G. GORTON. 247

X. DIRECTIONS FOR CHANGE 254

Androgynous Maturity and the Nurse Practitioner.....MARTHA STURM WHITE . . 255

Where Do We Go From Here? Strategies for Change......SHERYL K. RUZEK . . . 265

XI. BIBLIOGRAPHY 277

XII. PARTICIPANTS - WOMEN'S LEADERSHIP AND AUTHORITY CONFERENCE 292

XIII. EVALUATION SUMMARY 295

WOMEN'S LEADERSHIP AND AUTHORITY IN THE HEALTH PROFESSIONS CONFERENCE

SPONSORED BY
THE PROGRAM FOR WOMEN IN HEALTH SCIENCES
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
HELD AT OAKES COLLEGE, UNIVERSITY OF CALIFORNIA, SANTA CRUZ
JUNE 19-22, 1977

CONFERENCE AGENDA

Sunday, June 19

5:00 p.m. on	REGISTRATION: Oakes College, University of California, Santa Cruz
6:00 - 9:00 p.m.	BUFFET SUPPER
8:00 p.m. on	Informal discussion with conference participants

Monday, June 20

7:45 - 8:30 a.m.	BREAKFAST
8:30 - 9:00	WELCOME: Patricia Bourne, Conference Co-Convenor, U.C. Santa Cruz Lucy Ann Geiselman, Director, Program for Women in Health Sciences, and Assistant Vice-Chancellor, Public Program and Continuing Education, U.C. San Francisco Sheryl Ruzek, Conference Co-Convenor, U.C. San Francisco
9:00 - 10:00	OPENING ADDRESS: Norma Wikler "COMING IN AND MOVING UP: WOMEN IN THE HEALTH PROFESSIONS"
10:00 - 10:15	COFFEE
10:15 - 12:30 p.m.	WORKSHOP I: PROFESSIONAL DEVELOPMENT AND SOCIALIZATION: NETWORKS, MENTORS AND ROLE MODELS MODERATOR: Sheryl Ruzek PANEL: Rue Bucher Arlene Daniels Gladys Handy Florence Haseltine Rachel Kahn-Hut Joanne Lewis Mary Rowe Margaret Wilkerson
12:30 - 1:00	Divide into small discussion groups for lunch (Buffet Food Service, 1:00 - 1:45)

2:30 - 4:30	WORKSHOP II: THE SOCIAL ORGANIZATION OF PROFESSIONS AND HEALTH INSTITUTIONS IN HISTORICAL PERSPECTIVE MODERATOR: Carole Joffe PANEL: Bonnie Bullough Suzanne Estler Betty-ann Hoener Mary Howell Amber Jones Lois Scully Donna Ver Steeg Mary Roth Walsh
4:30 - 5:15	Small group discussion
5:15 - 7:00	OPTIONAL: SWIMMING CAMPUS TOUR SOCIAL HOUR
7:00	DINNER
8:15 (Optional)	STAFF INTERACTION IN A MENTAL HEALTH CENTER Video Tape Showing and Discussion by Nancy Henley

Tuesday, June 21

7:45 - 8:30 a.m.	BREAKFAST
8:30 - 10:30	WORKSHOP III: CAREER PATTERNS: CHOICE AND CHANNELING MODERATOR: Tora Kay Bikson PANEL: Catherine Anthony Lynne Davidson Jacquelyne Gorton Georgina LaRussa Jean Lipman-Blumen Judith Lorber Eileen Shapiro Martha White
10:30 - 10:45	COFFEE
10:45 - 11:45	Small group discussion
11:45 - 12:30	LUNCH
1:00 - 3:00 p.m.	WORKSHOP IV: POWER IN PERSONAL INTERACTION MODERATOR: Patricia Bourne PANEL: Georgie Anne Geyer Nancy Henley Paula Johnson Jane Mansbridge Virginia Olesen Candace West

3:00 - 3:15	COFFEE
3:15 - 4:15	Small group discussion
4:15 - 5:30	Concluding Session
6:00	DINNER
7:00	Conference Concludes

Wednesday, June 22

6:00 - 9:00 a.m.	COFFEE, BREAKFAST ROLLS (For participants staying over for return flights East)

OPENING REMARKS

PATRICIA BOURNE, Conference Co-convener, and Assistant Professor, Department of Sociology, University of California, Santa Cruz

LUCY ANN GEISELMAN, Director, Program for Women in Health Sciences, and Assistant Vice Chancellor, University of California, San Francisco, Continuing Education and Public Programs

SHERYL K. RUZEK, Conference Co-convener, and Community Coordinator, Program for Women in Health Sciences, University of California, San Francisco

WELCOME

Patricia Bourne

Welcome to the University of California campus at Santa Cruz. This conference is being held at Oakes College, one of eight colleges in the Santa Cruz complex. We are grateful to them for our comfortable accomodations and for the provision of this beautiful site, so conducive to fostering collegiality and the stimulation of creative endeavors. May our work here over the next two days mark a significant advancement in helping to move women into positions of leadership and authority in the health care professions.

I would now like to introduce Lucy Ann Geiselman, who will give you some brief background on how the Program for Women in the Health Sciences came into being at the University of California in San Francisco.

HISTORY OF THE PROGRAM FOR WOMEN IN HEALTH SCIENCES

Lucy Ann Geiselman

This program began about two and one half years ago, when Martha White and I began to talk about the need for the recognition of special concerns of women in the health professions. Dr. White's work on women in science and her research on career patterns of women is well-known and highly respected. I see a number of you have mentioned her research in your papers for this meeting, and certainly her scholarly contributions to the conceptual base of our program were enormously helpful in the beginning and her support of the program continues to be a valuable source of strength.

Dr. White and I spent months talking to each other, talking to faculty members, and writing to colleagues and other resources about some of our hopes. Two years ago we met Maggie Matthews from the Office of Health Resources Opportunity in the Department of Health, Education and Welfare and told her what we were up to. About the same time, we talked to our Chancellor, Vice-Chancellor, and Deans, and they gave us a small grant of $10,000 to begin the program. Instantly, we went out and bought our stationary, knowing that the program was firmly established in the bureaucracy of the University of California, San Francisco!

In January, 1976, Dr. Matthews visited us at UCSF, and we began a conversation that led to a request from HEW for a proposal to them from us. Ultimately, a contract was awarded in July 1976, and the program became operational in October. Dr. White was with the program as we recruited our staff and established much of the foundation and focus of the program. She returned to the School of Nursing and her research in December. It seems uniquely proper that a women's program should have a "founding mother," and certainly, that is the role that Dr. White has played in our program. We are indebted to her for it and hope that our work has been and continues to be consistent with her high values of scholarship and ideals of excellence.

Our belief is that barriers exist for women in the health sciences, even though, as all of you know, there has been considerable progress in access to education and training in the health sciences for women in the past few years. Indeed, we understand that the national average for women entering medical school is now considerably over 20 percent; on our campus it is over 40 percent. There has been almost equal, but not quite so dramatic, progress in dentistry and pharmacy. Obviously, the time is now to begin to develop programs which will provide greater access for the employment of women and their advancement into leadership positions across the wide spectrum of professions and occupations in the health sciences. We at UCSF want to help establish some of those programs. We have begun to do so and expect to continue to work in this area.

Some of our accomplishments and goals include:

1. Establishment of a resource and guidance center to identify career barriers for women in the health sciences;

2. Designing programs to enhance women's functions for professional and personal growth;

3. Collection of information on traditional and newly emerging health occupations and professions;

4. Conducting workshops and special activities to facilitate the career development of women across the continuum of professions and occupations in the health sciences;

5. Sponsoring local, regional, and national symposia, colloquia, and conferences in order to identify and disseminate information on research, policies, and practices related to women's careers and women's health.

6. Incorporation of the concerns and perspectives of Third World women into all of our activities.

Next year, we hope to offer our programs on all nine campuses of the University of California through the statewide delivery system of the University Extension. Our goals are grand and our resolve is firm. And now I would like to introduce our staff, who will help us accomplish the task that we have set for ourselves, and at the same time to express my genuine and heartfelt thanks to them for the work they have done already in the preparation of this conference.. Velma Parness, Program Manager; Jean Born, Resource and Guidance Coordinator, Gleoria Bradley-Sapp, Administrative Assistant, Verena Fong, Secretary; Patricia Bourne,staff member "out of residence" and co-convener of this conference; Norma Wikler, another staff member "out of residence."

I would now like to introduce to you Sheryl Ruzek, Community Coordinator of our program and also co-convener of this conference. A sociologist, Dr. Ruzek brings to us her research talents and a truly remarkable understanding and special interest in women's careers in the health sciences and health fields. As an academic administrator, it has been a special privilege for me to work with her and other experts in the development of this program and, indeed, talk on form and substance to make this conference happen. I am honored by that association and it is a great pleasure that I present to you Dr. Ruzek.

PURPOSE OF THE CONFERENCE

Sheryl K. Ruzek

A major task of the Program for Women in Health Sciences is to assess women's roles as health care providers and to identify barriers to women's career development across the spectrum of health occupations and professions. To do this, we are reviewing the existing literature and interviewing key persons, especially in areas underresearched in the past. For example, the role of ethnic minority women in the health professions and health occupations has largely been ignored. This is an area in which we hope to stimulate more research. We are also holding a series of workshops and conferences and informal discussion groups to gain ideas and insights on how to improve women's opportunities for satisfying, meaningful careers in the health professions.

This conference is specifically designed to identify and assess career development issues for women at the top, women already in positions or moving into positions of leadership and authority. In the next two days, we ask all of you to share with us your information and knowledge acquired, not only through your research and practice, but through your personal experience as well. For most of us here have experienced in one form or another many of the situations and issues that we will be talking about. We feel that this kind of personal knowledge--of wisdom of experience--is sorely needed at this time.

By the end of the conference, we hope to have generated interest in a wide array of issues. These issues and concerns will be communicated to appropriate training and professional institutions and public and private funding sources as priorities for research, policy, and programs. We especially hope that you will incorporate some of the ideas discussed into your ongoing and future research, practice, or teaching.

The conference format offers working sessions rather than formal presentations. This reflects our desire to generate, collectively, directions for research and practice out of the diversity of perspectives we bring. We believe that an interdisciplinary approach is essential. As Norma Wikler will discuss, we are at a point where we have to rethink basic issues and concepts about women's careers and leadership and authority in various types of social institutions. Our research priorities, as well as our social interventions, need to take into account the complexity, diversity, and interrelatedness of issues.

The working sessions are also envisioned as real opportunities for dialogue and interaction between participants. As we developed topics and panels, however, we realized that many of the issues are so connected that it is hard to separate them. As a consequence, many of you could equally well address several different workshop topics or areas. We urge any of you who have experience or ideas to participate fully whether or not you are actually listed as a member of a particular workshop or panel.

Finally, this conference is intended to facilitate the growth of informal networks both within and between various disciplines. Because this aspect of the conference is so important, we have included biographical information in the packets to give you a chance to get acquainted with the work that your colleagues are doing. We also tried to leave enough loosely structured time for people to get together in small discussion groups and informally in the evenings to exchange information and ideas.

To give more structure and focus to the conference and to put the issues in perspective, we have asked Norma Wikler, a sociologist from Kresge College at the University of California, Santa Cruz, to present an overview of key issues from her perspective and as they emerged in the papers you sent to us. I am delighted to introduce Norma Wikler who will speak on "Coming In and Moving Up: Women in the Health Professions."

III.

KEYNOTE ADDRESS

COMING IN AND MOVING UP:
WOMEN IN THE HEALTH PROFESSIONS

Norma Juliet Wikler

Dr. Wikler wishes to thank Sheryl Ruzek for her many helpful comments and suggestions.

COMING IN AND MOVING UP: WOMEN IN THE HEALTH PROFESSIONS

Norma Juliet Wikler

In June, 1977, we have a national conference on women's authority and leadership in the health professions. In itself, this is testimony that something very significant has occurred on the American health care scene. Until very recently (except within nursing), few women were in the health professions and fewer still in positions of leadership and authority. Even by 1975, no other country in the Western developed world, except Spain, had a lower percent of women in the health professional labor force than the United States. Even a few years ago, we would not have had much to talk about.

Today, however, we can and must address this topic. Women in large numbers are entering the traditionally male health professions. At the same time as nursing dramatically changes, expanding its roles and responsibilities, increasing numbers of men are entering this field. Also, new allied health professions, some of which extend the traditional nursing role, are proliferating. All of these changes vitally affect the status of women in health. It is time for us to come together and take a close look at the field.

In the years between 1965-1975, the women's movement focused on breaking the barriers of entry to the traditionally male professions by fighting, through affirmative action, the discriminatory policies of training institutions across the country. I call this the decade of the "first struggle" of women in the health profession. This was also the period in which nurses began to formulate their challenge to the male medical hierarchy. The gains of the first struggle are indicated in the statistics on the proportions of women in the health professions' schools. Just within the four years from 1970-1971 to 1974-1975, the first-year enrollment of women in schools of medicine increased 161%, dentistry 571%, veterinary medicine 183% (URSA: 1976). And this year a number of medical schools across the country have 30-40% women in their entering class. The gains made by nursing are most visible in the changes in legislation governing nursing practice and in the growth of the nurse practitioner movement, which has extended the nurse's authority and autonomy.

Today, the first struggle continues. We must not abate our efforts to encourage women to enter the health professions and to expand their options within them, and we must continue to enforce the legal and institutional mechanisms which were developed to fight discriminatory policies. But now, in 1977, we must broaden our concerns. I believe we have entered a new phase. What I call the "second struggle" has begun. This involves not only moving women into the various areas of health, but moving them UP--in their institutions and professions, as well. The second struggle begins at a time when the relatively large cohorts of women who entered professional schools during the first phase have completed their training and begun their careers. What barriers must they scale now in order to fulfill their expectations and ambitions?

It is clear from all the data we have on women in the health professions that numbers alone will not ensure their rise to positions of authority and leadership. As is common to all professions, women remain concentrated in the lower level of whatever stratum they find themselves. If at the top, then they are at the bottom of the top. For example, in medicine women are predominantly found in specialties lowest in pay and prestige. They have been greatly underrepresented in roles of professional status and power. According to a 1976 national study of eight health professions, the trend continues (URSA: 1976).

The problems facing us now--moving women up to positions of authority and leadership--are subtle and complex. In addition to the key areas of our concern in the first struggle--female socialization patterns, women's roles and women's place--we must now gain understanding of the nature of complex organizations, the structure of health institutions, and the factors which affect professional development and careers. To analyze these problems and to develop strategies for change, we must draw on all the talents and skill which we bring here today from our diverse backgrounds, perspectives, and experiences.

The Second Struggle

The second struggle must be waged on various fronts. Of the many issues which are salient now, I would like to identify four which I believe warrant special investigation and concern. They bear on women during their training for health careers and later in their professional work. The first is an issue which until very recently has been unexplored. That is, the nature of hierarchical institutions and the effects of hierarchy on women health professionals. The second issue, sexism, continues from the first struggle. But because of the changes which have taken place in the past decade, and because of the new tasks we have before us, we must rethink our conceptions of sexism and examine the phenomenon in new ways. A third issue, central to our intellectual work, also emerges. One can see the visible indications of its growing concern, especially to female social scientists, by reading the journals. I refer to the task of revising our models, theories, and conceptions of gender or sex differences. Finally, there is the issue of male identification. Already in the second struggle, many professional women have expressed concerns about the ways in which traditionally male roles and participation in hierarchies affect them, both individually and collectively as a member of a struggling minority.

1. Hierarchy

In our discussion of the first issue on hierarchy, we must recognize that women entering male roles confront the necessity of moving up in an array of overlapping hierarchies. Most obviously, it means gaining authority and leadership in their institutions of work--in hospitals, universities, government agencies, health departments, or clinics. But, in addition, to gain power, it is also necessary to move up in professional hierarchies. In formal professional associations, such as the American Medical Association and the American Nursing Association, significant decisions and policies are established. And informal collegial networks provide opportunities essential to professional careers. In the first struggle, we conceived the barriers to women's mobility to be either blatantly discriminatory policies and sexist attitudes or psychological problems of women, such as limited aspirations and motivation and fear of success. In the second struggle, we must take account of the structures in which these aspirations, motivations, and fears are shaped and recognize that mobility depends, also, on access to the male elite networks in institutions and professions and to sponsors and to mentors all along the way.

Power in hierarchy also involves the hierarchical relations among professions. In nursing, for example, this entails challenging the medical hierarchy for more autonomy, authority, equality. Though females overwhelmingly predominate in numbers in nursing, their positions of leadership and authority within the field are not necessarily secure. Research by Gross (1968) and, more recently, Grimm and Stern (1974), prove that as men enter traditionally female fields (the latter researchers studied nursing, teaching, social work, and librarianship) they assume the administrative, supervisory, more prestigious roles. Finally, it is ironic that at the time when women are struggling to achieve sex balance in traditional health fields, we face the spectre of newly created allied health professions - such as the Physician's Assistant and the Nurse Practitioner--which recreate between them the previous inequalities of power, status, and remuneration.

2. Sexism

The second issue is sexism, our old enemy. As in the first struggle, we pose the same questions: what are the forms of sexism, what are its manifestations, and how can we combat it? One thing we have learned clearly over the past 10 years is that sexism takes many forms. It is embedded not only in the attitudes of individuals, but deep in the structures of organizations and institutions. I would argue that the medical world and its health institutions - based as they are on male ideology, male characteristics, and the male social roles - constitute in their structures a "discriminatory environment," which may be obscured from our view by superficial changes in policies and behavior.

The more subtle forms of sexism which we are encountering in the second struggle do not lend themselves necessarily to the remedies we used in the first. Affirmative action policies were successful in increasing the numbers of women entering health professional schools and they also facilitated the entry of a few women into top positions in medical institutions. But how well can they serve to combat the sexism which occurs in the informal processes by which individuals move up in institutions and gain authority and power? And what do we do about the day-to-day nonactionable incidents of discrimination which constitute powerful barriers to women in their work? We were certainly not welcomed with open arms into the lower ranks of traditionally male professions. We can anticipate even more resistance to our efforts to rise up and take positions of power over men. Not only are we up against the well-documented displeasure men express in having women in authority over them, but also their fear that too many women--especially in positions of leadership and power--will bring down the status of the profession. Their fears have been born out in every occupation in which this has occurred, not only in the United States but other countries as well; a sad commentary on the status of women throughout the world.

3. Sex Differences: Male and Female

I would now like to talk about the third set of issues, those concerning male and female sex differences. The quality of our research on women in health and the soundness of the policies and programs we develop from our findings depend ultimately on the validity of the models, concepts, and theories we use in understanding gender and sex differences. How we conceive of the traits and characteristics of "maleness" and "femaleness" are central. During the first struggle, most of the research on sex roles considered these variables as dichotomous and assumed that the effects of sex differences could be assessed without reference to actual and specific situations. Female behavior patterns and psychological traits, acquired through socialization for female roles, were deemed immutable and incongruent with male professional roles, regardless of the context. From the research, we have learned a great deal. However, in terms of predicting or accounting for the actual experiences of women at work, this approach provides an important but only partial segment of the picture.

Now we are beginning to see studies of professional women in concrete empirical settings. For example, Rosabeth Kanter (1977), who unfortunately could not be with us at the conference, has done recent research on women in corporations. Her work has yielded new insights into the ways in which context and situation affect the salience and consequence of gender. In her writing, she makes the case for an absence of sex differences in work attitudes and behavior, arguing instead that they are a function of location in organizational structures of opportunity and power. Men placed in disadvantaged positions similar to women were found to exhibit the so-called feminine work attitudes and behaviors supposedly dysfunctional for mobility. Her findings, based on this "it's what's outside that counts" approach, lead her to conclude that equity in the workplace requires that hierarchical arrangements - rather than the women - be changed.

I believe that we are at a point of new intellectual departure. We are ready to synthesize the "what's inside" and "what's outside" perspectives. Our task now is to explore the ways in which gender characteristics are interwoven within each person and in the daily fabric of social activity.

4. Change

Our final issue, male identification, is confronted as women actively engage in the second struggle, moving into male roles and up in hierarchies. Do women become like men? Should women become like men? Must women become like men--in terms of career patterns, interpersonal style, modes of exercising power, and repertoire of skills? Or, do we have the alternative to forge new structures and styles? The answers to these questions have enormous consequences for women health professionals, the institutions in which they work, and the product of their labor: research, patient care, and the training of future practitioners. We know so little about this topic. Yet there is hope, broadly raised, that women will somehow "humanize" health care in America. But there is also fear, expressed especially by those who are trying to do just that, that their own individual humanity might be lost in the process.

All of these four issues are even more formidable to women who are also members of ethnic minorities. Often, they see their struggles as separate from and sometimes in conflict with those of privileged white women. Although we can expect that the issues raised in your papers and those which I have discussed so far apply to all women, we must not assume that we have identified the problems of greatest urgency for Third World women.

One of the most important tasks of this conference is to identify the issues of most concern to ethnic minority women in health and to formulate designs for long-neglected research and programatic development. In the past, women's roles in health were invisible. Today, we can document the work patterns and professional activities of women in general, but minority women remain invisible, lost somewhere in the statistics of white women and minority men.

The Conference

The workshops of our conference have been organized around four distinct substantive topics: professional development and socialization, the social organization of professions and health institutions, career patterns, and power in interpersonal interaction. In addition to discussing these topics, we will see that the issues I have just outlined in brief form are also addressed by many of the papers submitted. These issues run "vertically" through each of the workshops. To give you a sense of how they are related and also a tantalizing taste of what is to come, I would like to briefly indicate how these themes may be elaborated in the workshops. My remarks can only highlight certain points raised in the papers; many commented on a number of issues.

Several papers dealt with hierarchy and the networks, mentors, and sponsorship systems associated with the health institutions and professions. Informal networks are one of the most important means by which men and women move up. In her paper, Arlene Daniels argues for the critical need to develop feminist networks in the health sciences. Her remarks include a description of some of the unique barriers to women's mobility arising from training and practice in the health care system. Amber Jones' analysis of the career patterns of women in medicine gives us a great deal of information and raises provocative questions concerning the status of women within the current hierarchies of this profession. Her insights into why female physicians have rarely held leadership positions in the past and what tools and skills will be necessary for them to acquire if they are to do so in the future, are most important. Some of these insights were explored in depth in other papers and will be raised in the workshops by other participants.

Suzanne Estler's description of the processes by which lower, middle, and top positions are filled in organizations across all sectors of the economy can serve to illuminate the particular difficulties women face as they attempt to move up in medical hierarchies. According to Estler, one of the elements which enhances the chances for promotion at different organizational "filter points"--the screens between the various structural levels of an organization--is the influence of a mentor. But, for reasons which she elaborates, men at higher levels are often hesitant to adopt a woman in a mentor relationship. Suggestions as to how to overcome this have been offered by Mary Rowe. Her forthright statement, "Go Hire Yourself a Mentor," serves as a guide to women in finding and using this special instrument of mobility. In our first workshop, we must examine the difficulties in doing just what she suggests and consider how those difficulties are compounded for Third World women.

Both Estler and Rowe referred to the importance of a mentor for the trained professional. Such sponsorship is equally important, if not more so, for women in health training schools. Judith Lorber has written previously about the exclusion of women from studies of career training and work situations in medicine and the ways in which this exclusion has obscured the systematic biases which result in the channeling of women into work low on the hierarchy of pay and prestige. She discusses her current research concerning the sex imbalance in medical specialties, which results both from self-selection and from tracking by faculty via the all-important informal professional sponsorship system.

In addition to learning about the character of hierarchies in the health professions as they now exist, we will also address this larger, perhaps more difficult question: In order for women to gain positions of leadership and authority, should hierarchies be joined, transformed, or destroyed? Several of the papers tell us what is needed to effect each choice and some of the possible consequences thereof. If nurses are to assume full leadership within their own profession and join the hierarchy of medical institutions, they will need training and new skills. Jacquelyn Gorton reports on the creative leadership development training program for graduate nursing students at U.C. San Francisco. From the evaluation of the effectiveness of the program thus far, it seems probable that nurses will increase the pace at which they are assuming their rightful place of power in the health field.

Part of transforming the medical hierarchy involves structural changes in training curricula and the organization of medical work. Reduced-schedule residencies represent one concrete approach in this direction. Eileen Shapiro reports on the issues involved in establishing reduced-schedule residencies on a national basis. Although this program was originally designed for Harvard Medical School Department of Psychiatry's "Mommies in Medicine," it is now expanding as an option for both men and women in a number of speciality areas and has many implications for the traditional medical hierarchy.

Jane Mansbridge's case study of Helpline, a community service organization, gives pause for reflection to those who believe that abolition of rigidly stratified hierarchies, such as those that characterize the health care world, will necessarily ensure women's rise to power. In 1971, Helpline workers organized themselves by small work committees and instituted decision making by consensus procedures. But, despite the open access to power and equal participation, the women maintained "non-powerful" self-concepts which led them to opt for invisible, behind-the-scenes positions of power. It would appear from Mansbridge's analysis that changing the formal organization and hierarchy are not enough; for women to choose positions of power and exercise them without strain and ambivalence, they must also develop appropriate self-concepts and have access to female models who are effective in their use of power.

As I mentioned before, hierarchies of power and prestige are developing among the proliferating new allied health professions. Bonnie Bullough's paper presents an extensive and penetrating analysis of the barriers, past and present, to the Nurse Practitioner Movement. Why did nursing allow the Physicians Assistants to move in and preempt the needs which they, as nurses, could fill through their expanded role? This paper provides some answers. I am particularly interested in her argument that ingrained behavior patterns - what she refers to as "the games nurses play" - continue today to maintain the subordination of nurses within the traditional medical hierarchy.

A number of the papers address the issue of sexism--its forms, manifesttions, and strategies to combat it. Their analyses provide a starting point for reassessment and re-examination of remedies we have relied upon in the past and serve as a guide to future actions.

Joanne Lewis comments on affirmative action programs and suggests the factors which have proven most effective in facilitating positive change. She includes in her observations the personal characteristic of individuals in key positions which may ultimately determine the outcome of the programs. Affirmative action laws and policies are concerned with "actionable" instances of sex discrimination. What about nonactionable actions, the minutiae of sexism and racism, instances perhaps trivial in themselves, but which--and here I quote Mary Rowe's apt phrase--taken together, like the dust and ice on Saturn's rings, constitute formidable barriers to women? Florence Haseltine discusses Rowe's research on the micro-inequities in the American economy and raises the related issue of the difficulties and strains role modeling places on the few women who have moved up in organizational hierarchies.

Eileen Shapiro, like Mary Rowe, has been directly involved with counseling women in training and in work who perceive themselves to be the victims of nonactionable sex discrimination. She offers a "Survival Guide" based on her experience of effective responses to such incidences.

Nancy Henley and Candace West provide us with papers which show how hierarchy perpetuates sexism in the social dynamics of everyday life. Henley focuses on the interrelationships among power, sex, and nonverbal communication, noting how male gestures of dominance and power and other forms of nonverbal behavior reflect and maintain the disadvantaged position of women. West's analysis of conversation and power between men and women gives us another example of the ways in which informal interaction may systematically discriminate against women. Her study shows how male dominance and control may be maintained through the conversational device of interrupting speech. West notes in her paper that her findings lend support to the hypothesis that certain situations may render gender patterns more or less salient.

In addition to the issues of hierarchy and sexism, we will also address the third intellectual task mentioned earlier--that of rethinking our notions, theories, and models of sex differences and their consequence for women in professional work. Several of the participants in this conference will focus on some aspect of this issue. Martha White presents a critique of the trends in sex differences studies over the past few years. The failure of the research she reviews to consider the integration of sex role identity as a developmental process and to study self-sex definitions, instead of stereotypes, bears important implications for our understanding of gender. White's new formulations take us an important step towards rectifying the overly simplistic notions which have been in use.

Turning from sex to race, we must also move beyond simplistic conceptions and analyses. Our limited efforts at understanding the unique experiences of minority women have been based on scant empirical data. For example, Cynthia Epstein (1973), in her study of black women lawyers, came to the surprising conclusion that the effect of having two ascribed negative statuses--female sex status and race status of black--did not result in negative consequences for these professional women but formed, instead, a positive matrix for a meaningful career. While this may indeed be true for a limited number of women, we suspect that such formulations require more critical examination. Gladys Handy comments on this phenomenon and cautions us against overgeneralizing Epsteins' conclusions. Handy's own experiences have demonstrated the importance of context on the interaction of the attributes of sex and race. In some situations, the multiple deviant statuses may cancel each other out; in others, they may be compounded; in still others, neither may be salient at all.

Lillian Cartwright and Georgianna LaRussa utilized longitudinal data on a sample of 49 women who entered the University of California medical school in the late sixties. They were interested in identifying the factors which differentiate those who have had continuous careers from those who, at one point or another, interrupted their careers. Their data reveal differences between groups, not only in the area we might expect--choices made concerning family formulation--but also differences in personality. Given the apparent predictive value of the factors they identify, we should investigate whether such psychological dispositions are immutable or subject to alteration and modification.

In a study on which I will comment in a moment, Rue Bucher and Joan Stelling concluded that professional identities are constructed during the training experience through a complex interplay of structural and situational factors. Their findings stimulate us to look for the special conditions in health professional schools and in work environments which may override personality factors in determining careers. It will be a major task of the second struggle to analyze how these personality traits, acquired through early socialization, may be altered in the decades that follow.

Cartwright and LaRussa were careful to avoid judging the value of the career patterns in the two groups they studied. However, their findings show a negative relationship between traditionally feminine characteristics and upward mobility.

In contrast, Jean Lipman-Blumen's work on achievement orientations leads us to re-evaluate the assumed incompatibility and handicap of typically female traits in male professional roles. Her assessment of the contribution which the "vicarious achievement pattern" associated with females can make to many occupational roles encourages us to investigate the positive aspects of female traits and their usefulness in moving up in hierarchical institutions.

The model of professional socialization, developed by Bucher and Stelling in their research on four postgraduate training programs, stresses the way students interpret, evaluate, and respond to the structural and situational features of their environment. Role playing and the consequent mastery over the knowledge and skills of practice is the most central element in the development of a professional identity. How this process of socialization differentially impacts on the sexes and in what ways, if any, the distinctive characteristics and qualities of women are modified--wittingly or unwittingly--in the process are important considerations.

I doubt that there is a women here who has not reflected on the issue of male identification and wondered what changes in personality, style of interaction, and repertoire of skills she might be forced to make in order to succeed in a male professional role. Some of these changes, such as the acquisition of skills in leadership and the exercise of power, are usually considered not only necessary, but desirable. But other changes can seem in violation of our beliefs, values and, perhaps, feminine disposition. The papers of Paula Johnson, Donna Ver Steeg and Lynne Davidson shed light on different aspects of this theme.

Women have had little experience in the exercise of political power. Yet now, more than ever, that skill is important to the nursing profession--especially in influencing legislation governing nursing practice. But most nurses (as is true for most women) lack the knowledge and the administrative and social skills to exercise such power. Donna Ver Steeg has focused on this topic in a published article. She will discuss this matter and also her current involvement in training nurses to assess power in their work settings. Power and influence are also a part of everyday life, an aspect of social interaction. Paula Johnson's research on expectations of male and female modes of influence in day-to-day interaction tells us that in order for women to gain more power and leadership they will have to adopt the more direct modes of power, which are now typically male. For such transformation to take place, Johnson argues that women must gain access to professional and institutional positions in the health system, as elsewhere, which provide the concrete resources, such as money and knowledge, which underlie these effective modes of power.

Many women find one of the most stressful aspects of medical training and practice to be the clash between the valued feminine traits of nurturance, warmth, and expressiveness and the professional norm of "affective neutrality"--that is, the proscription of effective involvement of health workers with their patients. Lynne Davidson's study of the extent to which male and female physicians actually control affects, such as sympathy and involvement, reveals that women physicians have different opinions as to the medical value of traditional female traits. Some think that these qualities enhance the doctor-patient relationship; others feel that these female-associated attributes cause them to be perceived by others as too emotional and affective and, therefore, less professionally competent. At least for women in Davidson's sample, the issue of should women change was undecided. My own work (with Pat Bourne) on women in medical schools and my research on women in academia convince me that this is a pervasive problem for women, probably in all professional roles.

Where Do We Go From Here?

The papers submitted to this conference make a valuable contribution to the understanding on which our efforts in the second struggle will be based. But the purpose of this conference is not only to share and assess what we now know about women in the health professions, but also to propel us forward. I would now like to briefly outline the thrusts of some research which I think will be most important in the future.

We need much more research on how behavior related to sex roles varies as a function of social context at the broad "macro" level of social institutions and also at the "micro" level of small groups. We need to investigate the ways in which the structure and organization of health work provides conditions more or less favorable to women. For example, one very important trend in the American health care system has been the gradual changes in the organizational and economic bases of health care delivery--away from the once predominant entrepreneurial model (the independent medical practitioner) towards groups and institutional forms, like health maintenance organizations. This would appear to auger well for women physicians, since institutionally based health care provides the flexibility which could accomodate women's dual familial and professional roles. Yet we must ask--what are the hazards and potentials for exploitation as women become more dependent upon large-scale institutions and have fewer opportunities for independent practice, an organizational form which historically has provided deviant practitioners opportunities unavailable in institutions controlled by dominant groups? This situation is particularly acute for Third World female practitioners, who might find themselves increasingly channeled into salaried employment in institutions specifically set up to serve low-income populations. While this may offer more comprehensive care to minority patients, it may, at the same time, restrict the more rewarding work opportunities for the practitioners.

In addition, the flexibility offered by health institutional settings, while providing short-term gains to women, might, in the long run, doom them to marginal careers. If women, and not men, take advantage of this flexibility and opt for part-time or intermittent work patterns, realistically speaking, they will remain at the lower rungs of their professions and institutions.

At the micro level, such as the work groups, we must explore the interaction of sex-associated attributes and such structural factors as the sex ratio of the members. The work has begun. Ruble and Higgins (1976) recently reviewed the psychological literature on the topic, which conclusively shows that the sex compositions of the work group--of both children and adults--affects in a variety of ways the sex-role awareness and sex-related responses of members. Wolman and Frank's research (1975) on the deviant roles forced on the solo woman in a professional peer group provides forceful evidence for that which many [illegible] us have experienced personally--the inherent frustration and ineffectiveness of being the single or token woman in an all-male professional group. Women health professionals, faculty, and administrators can use this sort of information in organizing mixed-sex work groups which maximize the comfort and productivity of the members.

Surely one of the most important goals we should strive for is the development of concrete proposals for future research, programs, and policies which can facilitate the solution of the problems we have identified and analyzed. In the institutions of research and health care delivery, what are the structural changes and reforms which can directly serve the needs of women practitioners? Flexible curricula have been mentioned. We are aware of the pressing need for child care facilities and a "parental" leave policy which would make it possible for both men and women to combine their professional and familial roles. What else could ease the burdens on women with dual roles and multiple commitments? What are the strategies most effective for such institutional change?

Surely the organization of women is a key, and here I think we have lost some of the gains made in the first struggle. Many of my women colleagues at Santa Cruz and other campuses of the University of California have noted with dismay the demise of caucuses and groups of faculty women which had been active during the years of the most intense influx of women into academia. In my opinion, now more than ever, women need to be organized in their institutions and professions in various kinds of groups--support groups, caucuses, professional associations, and collegial networks. These "separatist" groups are essential for women's professional mobility, their penetration into male hierarchies, and their emotional well-being. Though necessary, Arlene Daniels will remind us that they are not sufficient.

Special programs which actively seek to identify women with administrative talents and interests and assist them in finding major posts could do much to hasten the entry of women into top positions of leadership and authority. In academia, as in the world of health care, there is a paucity of women in higher levels of administration. But now there is a national program underway which will do much to ameliorate this situation, as we will learn from Margaret Wilkerson's report on the National Identification Program for the Advancement of Women in Higher Education. As part of this program, a career advancement seminar was held just a few weeks ago on the Berkeley campus. The strategies they developed for effecting change and coping with institutional barriers may well be applicable to the health professions.

In my opinion, the second struggle also involves integrating the perspectives of the women's movement and feminism into the knowledge and techniques of professional practice. This is an issue we have not referred to before, but if we look at health care, especially in certain parts of the country, we can see that, to a limited extent, this has begun. In many hospitals the medical routines of childbirth have been altered to accommodate the claims that women--mostly in their roles as health consumers--have made over their bodies and their lives. It is worth reflecting on the fact that the most serious challenge to the traditional male medical hierarchies, thus far, has come from the women's health movement. The attempts of these women to demystify and democratize health care are described in depth in Sheryl Ruzek's forthcoming book on the women's health movement.

And finally, I would like to suggest that, although the conference will focus primarily on how we can help professional women move into and up in the corridors of power in the health professions, we should also be concerned with the broader goal of improving the conditions of the millions of women health workers whose jobs are characterized by being dead-ended and low paying and the millions of women health consumers whose needs have not been ideally served by the medical world.

To reach these broad goals, we must also have a broad perspective. The second struggle to achieve authority and leadership for women in the health professions, as elsewhere, will involve changing the social, political, and economic structures in which medicine is encompassed. It would be shortsighted of us, indeed, to believe that we can achieve our goals in the absence of changes in the general status of women in American society. The failure of passage of the Equal Rights Amendment indicates how far we have yet to go.

I have spoken in academic and intellectual terms, but the content of what I have said has personal and emotional implications as well. I see in this room, not only accomplished professional educators, researchers, and health practitioners, but also a collective body of women. Through our work and other activities, each of us here has already engaged the challenge: to transform the discriminatory attitudes and structures which have limited the full exercise of the energies, talents, and skills of women in health. We are now at a new point in our long and difficult struggle for women's full rights. Together we can change institutions and professions and pave the way for other women, and men, who wish to participate as equals in the American health care system.

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IV.

THE INFORMAL ORGANIZATION OF LEADERSHIP AND AUTHORITY

Leadership and authority are exercised through informal as well as formal positions and relationships in the health care professions.

Daniels discusses the importance of informal female networks and support structures for the advancement of women in the health sciences. Haseltine explores the ideas behind role models and mentors in facilitating women's career development and suggests some changes. Rowe offers practical advice on the value to women of seeking out and cementing relationships with potential mentors. Olesen reminds us that lower-status women in the healing and caring systems also exercise leadership and that their alliance with women in higher-status positions can effectively improve the social distribution of knowledge throughout the health care hierarchy. Many decisions about hiring, promotion, and personnel policy, for example, are influenced by the decision-maker's informal professional connections. In the national arena of professional politics where fateful decisions are made affecting the rank and file, these informal forms of power and influence (e.g. access to key legislators, recognition as an expert witness) are crucial. Women are rarely admitted to these inner circles of power and influence.

DEVELOPMENT OF FEMINIST NETWORKS IN THE HEALTH SCIENCES

Arlene Kaplan Daniels

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Arlene Kaplan Daniels

Practical common sense has always suggested the importance of informal networks within any institutional system or any community. Put most cynically, we say "it's not *what* you know but *who* you know." Even when we argue that both *what* and *who* are important, we do not deny the importance of contacts. The short cuts they provide around formal system of information and referral can be enormously useful. For example, personal recommendations for job applicants from trusted sources can be crucial, either when finding a job or when locating suitable candidates for a specialized task at the last minute in order to meet an important deadline. Similarly, quick information on issues that require speedy action--the best scholarly references, agencies, or key informants in preparing a grant proposal; the crucial areas to read in a bulky personnel manual or *The Congressional Record* when building a documented case on a topic--may make the difference between success or failure. The persons with the best contacts may be able to prepare themselves the quickest and may consequently look the best in some competitive situation. An additional value of informal networks is the help they can provide when one needs information on the best strategies or tactics to take for an administrative or political action. How should one approach a strange agency when requesting "delicate" information? Where should one first go for help in a bureaucratic agency, when ignoring the informal gatekeeper to resources can be ruinous? Knowing the right people means they can give you "tips" on how to manage such matters.

These uses of networks should not be seen as in themselves somehow immoral or illegal for they are often an important way to make the cumbersome machinery of bureaucratic administration work efficiently and quickly. The reassurance that information is received from trusted informants makes these short-cuts doubly efficient; they offer a means to select information, first evaluated by someone whose judgment is also valued. Of course, mistakes are possible--errors do occur in your judgment of your friend or your friend's judgment of what or who it is you need. But the network system generally works well enough for people to try it. Naturally, one returns more often to those who consistently offer advice that proves good. A success rate in using this strategy is based to some extent on a self-fulfilling prophecy. One generally chooses friends and confidantes from those with compatible values. Therefore, personal recommendations will reflect those commonly-held values. The advantage to this system, irrespective of how satisfied one is with such judgments, is that knowledgeable persons can survey their own territory and then make judgments similar to those the questioner would have made with similar opportunity. One expects those trusted for good judgment to give good advice on how to proceed over unfamiliar terrain.

These strategies are practiced in old boy networks, secret societies, and fraternal orders. And, since they are commonly associated with exclusionary or discriminatory treatment toward non-members, it is also common to regard this conception of network pejoratively. Yet doing so might lead us to overlook the positive benefits for members and the social-psychological importance of informal networks for the individual participants: a sense of mastery and a sense of self-worth. The first is provided in at least two ways. The knowledge of how to proceed through informal channels provides a feeling of efficiency and a sense of success when it produces better results than ordinary, formal procedures. Reputed whiz kids may gain their reputation by knowing where to get information for solving an administrative, research or technical question faster than anyone else. This reputation is thus built on the ability to make rational what one knows and then to tell it to others--or on becoming recognized as someone who knows important things about informal channels. Such a reputation leads others to show respect and to request information.

This process is likely to enhance the other personal gain from successful use of networks: the sense of self-worth. As theorists like Charles Horton Cooley have told us, one develops and maintains a self-image through the evaluation of us we perceive from others. Their view is inevitably part of our own reflection that we see in the mirror as we examine ourselves and evaluate our own performance and judge ourselves. Whatever other components it may have, our self-image is affected by the willingness of others to accept us into a network for it shows one is a person worth helping. When we are successful in using these channels--being helped and helping others--a sense of self-worth is validated. Finally, the respect of others and their requests for help reinforce a sense of self-worth. Thus, the farther "in" one develops a place within a network, the greater the opportunities for mastery and self-esteem.

Development of Feminist Networks

As women develop an understanding of how the social-psychological benefits of networking may be especially useful to those whose position in a sex-stratified system encourages no positive or unambivalent sense of self-worth, they perceive that informal "old boy" or "old girl" networks are not intrinsically bad. It is particularly easy for those disadvantaged in or marginal to the formal hierarchy to see how the formal communications networks are often too cumbersome, outdated, or inaccessible for many requirements. Understanding how important networks are is born out of experience--and necessity. Women have been learning how important are the resources provided by informal networks when no institutional channels exist to ensure entry and promotion to privileged positions for even the most worthy women. Networks provided by the women themselves are arising to parallel the existing old boy networks. These new channels make explicit what both formal and informal structures in education, business, and the professions have often left implicit: often the important information flow is managed on a sketchy, inefficient, and particularistic basis as situations and personal preferences dictated.

1. Socialization

Even specifically educational institutions often leave unspecified and unformalized some of the most important lessons they teach. Some students who do well are specially favored by mentors. Others are both sharp and lucky enough to be in the inner circle by students who learn from one another and also exchange information learned from those above them in the hierarchy. Still others, although apparently able from admission and early performance criteria, drop further and further behind. Proponents for affirmative action have long pointed to the disproportionate number of women and minorities in this last group; these proponents argue that the process begins early in education and also affects entrants into professional schools who have survived the early barriers. Women have some advantage over other minorities in that the privileged, white women among them have had more opportunities in education and sponsorship in the past. In consequence, sufficient numbers already exist, at least in some areas, to provide role models and mentors and to help socialize new entrants. The awakening realization of how important networks can be in this process has helped rationalize this area of informal socialization and has provided its justification. Older women thus come to see part of their personal and professional obligation as offering general advice and specific information to the new recruit. Younger or less experienced women can learn to ask for help and guidance without diffidence or fear of imposition.

2. Pooling Resources

Since resources--for informal socialization or anything else concerning the welfare of women--are still in short supply, feminist networks are used to fill gaps in information through pooling resources. Advice or teaching of informal socialization practices (how to manage a job interview; how to speak to a superior; how to manage home and career; where to get advice for filing a grievance against one's school or employer) can be offered through national and regional meetings and newsletters as well as local channels. In addition, specialists in one area become known for their expertise and are contacted from distant cities. Other resources are also pooled: long distance calls and messages are funneled through women with special phone privileges; some women may have secretarial and xerox facilities for mailing and duplication. Organizations cooperate in pooling mailing lists, non-profit franking privileges, legislative information vital for social action.

3. Networks with Outposts in Alien Camps

The development of a feminist ideology provides the basis for appeals to common interest across occupational hierarchies. As women in the high-status occupations take an interest in issues and problems affecting women in clerical and other lower status work, these professionals develop a sense of common identification. This sense is enhanced by the feminist ideology that women are all oppressed as a class whatever the distinctions in other privileges they may have. Where women share this ideology across class lines, underlings (secretaries, receptionists, clerks) may leak information to professionals (lawyers, academics, lobbyists, legislators) not otherwise accessible. "Old boy" bosses may then be astonished by the mysterious omniscience shown by those pressing for changes in the system. Advocates of affirmative action or other feminist causes may embarass the establishment or gnaw away at its bastions with their knowledge of inside practices or foreknowledge of strategies planned to thwart reforms.

In any or all of the ways suggested above, feminist networks can supply the personal or emotional support structure to dilute or negate the indifferences or hostility many women face when operating in a man's world. For these networks also supply the recognition mentioned earlier as one of the benefits of any insider's network. They offer help and consequent opportunities for success and a sense of mastery--for helper and helped. They provide reassurance, praise, and recognition to shore up a sense of self-worth. Equally important, success in these networks can promote and support successful entry into larger, heterogeneous networks of men and women. Finally, these networks can provide the necessary experience, self-confidence, constituency, and visibility to provide resources for infiltrating--or even crashing--the most recalcitrant and impervious "old boy" establishments and their networks.

Feminist Networks in Professions and Business Worlds

The opportunity to develop skills useful in infiltration or integration are particularly relevant to business and professional women; they inevitably face the necessity to accomodate to and change these virtually exclusive male territories. Some networks devoted to women's interests can exist and flourish with minimal attention to and from the male power structure. Nursery and childcare cooperatives, consciousness-raising groups for single, divorced, elderly, or lesbian women are often (though not always) in this category. Some networks can develop quite well independently, but ultimately must contact (and sometimes combat) the male establishment. Pregnancy, self-help, and general medical care counseling are clearly in this area. Turning from health issues--divorce, credit, and career counseling also fall within this area.

But women interested in succeeding within traditional male-dominated worlds know from the start that they will enter traditionally male-dominated worlds. They will need networks that are both separatist (so the opportunities of a women-organized network can be experienced) and assimilationist (so that opportunities to infiltrate the male hierarchy will arise). Two contexts are offered as examples of areas where women can benefit from feminist networks in infiltrating the professional networks now dominated by men: the professional convention and access to job openings in the academy.

1. The World of Professional Conventions

While the real importance of convention-going and paper-giving in any academic discipline or professional world is ambiguous, it is clear that these activities offer some general benefits, particularly in the early stages of a career. It is then that new entrants and junior practitioners have an opportunity to make contacts, gain visibility, and, if they are lucky, "learn the ropes" in the informal socialization process. Peers can pool knowledge, elders may be met in the friendly, relaxed, semi-sociable setting sometimes arising within the otherwise hectic and even alienating crush of a large professional meeting. In chance moments, then, friendship, tutoring, or collegiality may be offered. Occasionally as well, the avowed purpose of such meetings--the exchange of ideas in the forefront of research and the chance to exchange ideas with others of similar interest--may also be realized. Another avowed purpose of such meetings is to offer an opportunity for job seekers and recruiters to meet.

Unfortunately, the larger the convention the more difficult it is to assure these opportunities for any new entrant. Established professionals have many duties to perform for their association and must spend much time out of sight in committee rooms. In addition, they wish to meet old friends, enjoy the convention city, negotiate their own deals with editors and publishers, make their own contacts for research, academic, or publishing interests. The hopes of the established to make "good" professional contacts or contact with old friends divert attention from a junior who sees them as a potentially helpful informant several steps above. In consequence of these diverging interests, new recruits--both male and female--report they find professional meetings profoundly disturbing and alienating; they are often treated cursorily, indifferently, or even rudely. And little seems gained by attending. If one is fortunate enough to be in a profession which contains minority, women's, gay, or radical caucuses, the separate activities (or mini-conventions) provided by these groups can offer enough functions and interchanges to mitigate the loneliness and unpleasantness of the major gathering. In many women's caucuses within academic disciplines, a systematic effort is also made to provide useful information about "learning the ropes." (In Sociology, the Sociologists for Women in Society provided a number of "how to" sessions over the past five years to discuss such issues as writing papers, getting grants, establishing women's research projects, preparing articles for publication, managing the hurdles of graduate school and first jobs. These sessions were so successful and so well attended by women and men that a similar project has since been offered by the American Sociological Association. Currently, similar sessions are also offered in cooperation between the Society for the Study of Social Problems and Sociologists for Women in Society.)

These adaptations highlighted the fact that many new recruits of both sexes found professional initiation painful. A few of the favored might arrive with mentors and sponsors who eased the way. But most entrants were not so lucky and neither institutional supports nor supportive social contexts had developed to help them weather the period of initiation.

The more favored were taught early that conventions are more palatable when delivering a paper or serving as discussant or chair to a session; these activities provide a substantial reason for attendance and permit one at least an interchange with participants and audience for that session. A professor may write a paper with a student for a meeting, permitting the student to read it. Or, a professor may suggest a student in a special field of research to a panel organizer looking for likely participants in that field. Through the senior's greater knowledgability and influence, these opportunities are secured. But without this extra "edge" students often do not become aware of the requirements of submission and the best places to try in time to make deadlines. While these problems are faced both by men and women, it is clear that the consequences of naivete fall harder on more women than men.

The difficulties women face in gaining entry to the important professional experiences of meeting participation is also shown by the changes in numbers of women participating at conventions. Once women press for and win a significant number of the professional offices controlling access to the naming of panel organizers and session chairs, significantly larger numbers of women appear on the convention program.[3] A parallel difference appears in the rise in numbers of papers in learned journals authored by women when women assume key editorial management and advisory posts for these journals.[4] These opportunities offer women the visibility that also encourages invitations to conferences and conventions, furthering various informal opportunities for professional advancement.

None of these illustrations should suggest improper particularism or favoritism shown by women in their treatment of other women. Rather, the examples indicate both the difficulties and the importance of gaining attention in crowded, competitive worlds where even highly talented persons can go unnoticed without sponsorship or other advantage to spotlight their developing talents. Women are more likely to know other women, to encourage and be sought by them. Accordingly women will often know more about the work of other women than their male colleagues. In consequence, knowledgeable women will also know when it would be appropriate to recommend women for appointments. Such opportunities are especially important for women who, by their personal or general socialization in this society, have to struggle against a sense of unworthiness for or marginality to professional advancement in a man's world. As noted earlier, placement in a friendly network can go far in developing a sense of self-esteem and self-worth. A positive cycle of information feedback and professional reward will encourage continued perseverence by women professionals, preventing discouragement and self-doubt in the face of other less heartening experiences that commonly occur, even in the lives of favored white males.

2. Job Information Networks

While some might argue that the importance of participation in professional associations is overrated and that the advantages are dubious, everyone agrees that learning to behave as a professional has to occur somehow. A vital part of this socialization is learning how to get a job. Practically speaking, women need access to job information networks as much as they may need good references, a properly written curriculum vitae, and publications. If they have patrons, have attended a top, prestigious graduate school where their professors have themselves attended or taught at such top schools, and have wide contacts in the field, students are a step ahead in collecting job information. If, as in the case of many women and minorities, students have attended community and state colleges, worked or raised families, and then received graduate education at a university of middling reputation, students may have neither powerful or well-known references. One consequence may be no special knowledge of unforeseen opening and no insider's track on a possible opening where, after judicious informal queries, the recruitment committee comes to write job specifications just to fit a prospective applicant. In a tightening market, where hundreds of applicants apply for every job, "ordinary" applicants are lost in the first screening, through the flood of requests and vita arriving in response to every published job advertisement. No one known to the recruitment committee recommends them, no list of publications in prestige journals or papers read at professional societies proclaims their eagerness to show professional calibre even as a student. If no committee person sensitive to the particular career contingencies of women and minorities pleads for them, they never make it through the first round.[5] The advent of special networks in minority and women's caucuses within the professions has begun to provide alternative channels of information about such candidates. If established and trusted caucus members, themselves in the professional establishment, provide job information networks, if students at schools in the "boondocks" learn to use these networks, the chance may arise to reexamine the old self-fulfilling prophecy of many recruiters that "the best candidate will always be found in the top ten graduate school."

The creation of a dual system of networks can be one way to bridge the gap between the desire of new groups to gain acceptance and the needs of the existing system to admit and promote recruits. Those women acceptable to the established hierarchies and participants in it already have access to insider's information. Furthermore, the press to meet affirmative action legal requirements and social expectations about abandoning prior inequities make these women even more desirable as club members than they may have been previously. Now they are seen as necessary focal points for the gathering and dissemination of information about acceptable women recruits. It is expected that the older women, as already enrolled members of the establishment club, can be trusted to make judicious evaluations of these newcomers, telling the other "old boys" which applicant does and does not meet the current standards of excellence. In this way, they stand as "brothers" reporting on a foreign territory to colleagues at home, making decisions these colleagues might make if they knew that territory.

At the same time, these women, if they will show some sympathy and interest, are expected to stand as "sisters" to their junior women colleagues, encouraging their growth, helping their feminist groups to achieve solidarity and develop mutual support systems, offering "tips" from the inside, charitable contributions to struggling caucuses, providing references, long distance telephone calls, and xerox privileges to the less affluent.

In this way, dual systems or dual-purpose networks develop to promote solidarity within women's groups, while showing the way to assimilation in predominantly male professional clubs. The task for senior women is, of course, difficult. They become doubly marginal and can provoke mistrust from both groups by showing sympathy and familiarity with the other. Nevertheless, the success of many women's caucuses in academic disciplines rests on the efforts of such leaders, as well as on the genuine talents, energy, creativity, and perseverance of those new entrants knocking on the doors of the gentleman's club. The success of this venture is shown by how quickly a few new recruits have become elder stateswomen themselves in the past few years.

Special Problems for Women in the Health Sciences

The necessity for and difficulty in constructing such dual-purpose networks is nowhere clearer than in the male-dominated hierarchies of the health professions. The power of the male-dominated medical hierarchy over all other professions and services in health care has long been a characteristic of medicine in the United States. The power over licensing and certification is greater in the medical profession than any other profession. No other profession has the power to control or limit the powers of other professions as does the medical profession. In short, no other profession in this country is so autonomous and has so much power over other professions. While these powers are secured by legislation and maintained (even enlarged) by legislative lobbying and power to affect social policy, they are underscored by the mandate derived from the respect and honor accorded the medical profession by the public.

The consequences of this power is seen nowhere better than by the immense and unreviewed fees doctors can command. It is also seen in the power to define the style and tone of care delivery--as well as where and when it will be given--and how much it will cost. This control over definitions also includes how a problem will be defined (or diagnosed) and how responsibilities for tasks (or course of treatment) are to be delegated. One consequence of so much power (often criticized by consumers of care) is that the respect and awe of the medical profession may be used systematically to ignore complaints, misunderstandings, and dissatisfactions in care delivery. The doctor (generally male) operates as a closed system into which no corrective checks can be introduced should the system malfunction.

An additional barrier to any checks and balances in the system arises, in a sex-stratified society, when women are concentrated in the lower strata of the medical hierarchy as nurses, aides, and technicians. If most high-status persons are males and most lower-status persons are females, the sex stratification prevalent in the larger society is reinforced.

Difficulties of Forming Feminist Networks Across the Strata of the Medical Hierarchy

The long history of rigid stratification with strong lines of demarkation between physicians and all others, and parallel lines between various professions, semi-professions, technical specialties, and levels of skilled and unskilled service workers below the physicians creates a tradition of competition and rivalry over turfs. This competition is heightened by the press for certification among paramedical specialties desiring their own certification in emulation of at least some of the independence possessed by physicians. Each field wishes legally marked boundries between its own duties and prerogatives and those of others.

This press for independent recognition and existence leaves little time for concern with other areas and their problems. There is no identification of the common problem created by the dominance of the medical profession in the strictures on the certification of neighboring areas. In consequence, not much help comes from within the paramedical specialties when women-oriented fields desire recognition. Licensing restrictions and certification difficulties for mid-wives, pregnancy counsellors, abortion clinics, and self-help clinics are largely created by the medical profession--and largely ignored by the other specialties concerned with their own battles and eager to justify their own cause.

Solidarity across and even within fields is also mitigated by the traditional subservience patterns of paramedicals to physicians that encourages subordinates to identify with authority figures rather than peers. In hospital hierarchies, as well as clinics and other medical settings, there are special rewards for identification (special favors, extra personal attention) with physicians and punishments for refusal (harshness, difficult assignments, negative reports to higher administrative authority). Nurses may look to the new crop of residents and interns for marriage partners, resenting the women in the class who reduce the number of possibilities.

Difficulties of Developing Feminist Networks Within Medicine

The past scarcity of female physicians and their continued scarcity in fields like surgery--still virtually closed to women--encourages the identification of those women who have made it with male authority figures. These women experience a status somewhat like honorary males if they survive the socialization process. And the philosophy of tokenism encourages them to see themselves as different and special, unlike other women. These processes encourage indifference to or even fear of the possibility that greater numbers of women can and should become physicians. If they consider experience in other countries, American women physicians may be unfavorably impressed by the data showing how a great influx of women downgrades the status and economic reward available in medicine. Finally, their own place within the top stratum (even if they are in the lower part of it) encourages them to overlook or disattend the issues affecting the "masses" below. And even when they do wish to be sisterly and helpful, there are too few women to form the network of encouragement and support that could make such effort rewarding andeffective. In consequence, there are not enough women with the ideology or energy to want to help young women doctors, much less the paramedical numbers of women below.

The Feminist Movement as Impetus for Change and Growth of Feminist Networks in Health Care

Some preparation for women's networks comes from the flourishing union movement among paramedical specialties. In many of these specialties, women predominate and they are found in significant numbers among the leaders of professional associations and union officials. These are relatively new opportunities for learning the usefulness of cooperative interaction, the patterns of political negotiation, and the general usefulness of networking. They help to counteract the problems created by traditional subservience patterns. However, they do not counteract, but rather enforce, allegiances within specialties, just as they enforce defensiveness and antagonisms in contacts with persons in competing territories.

Feminism provides an ideological perspective to stress common, and minimize diverse, interests. The internal cohesion of unions and specialty organizations becomes a resource in the development of broader coalitions. The common interests rest upon the common experience developed through individual interactions within a sex-stratified system. Such common experiences promote sympathy for and interest in the plight of other women that can supercede some of the traditionally diverse interests of class and race, as well as occupational hierarchy. Here, it is possible that even the great barrier between professional and client can be crossed when women see their common interests and requirements in health care and the unique problems of satisfying these concerns in a sex-stratified system.

The feminist ideology provides a rationale--and strategies to promote it--in the health sciences. Such issues as the following are now under consideration: 1) how to bridge the professional/non-professional gap by stressing the common interests and sympathies to forge ties between academics, physicians, researchers, on one side of the gap and secretaries, nurses, aides, technicians, and custodial assistants on the other; 2) how to turn aside resentment of subordinate women when women join the formerly male hierarchy that is superordinate; 3) how to encourage the development and proliferation of organizations or coalitions of organizations to consider common interests or problems in working conditions, salaries, career opportunities.

The feminist ideology also suggests some of the immediate and personal benefits in the exhilaration provided by women working together. The literature on consciousness-raising groups in women's movement[6] suggests that untapped energies and potentials are released when women confront common problems in a group. The realization that many problems are not necessarily signs of personal inadequacy, but may well be indicators of both systematic and informal discrimination, may first evoke great anger. Ultimately, according to the ideology of this movement, the relief of not having the guilt and sense of personal responsibility for inability to achieve goals and general independence may release the energy for later success in these areas.

For those women in the health sciences who have already achieved--even in the face of those difficulties related to sex stratification--the sense of identity and sharing may be sufficient stimulation without the necessity for expressing resentment or anger against the male hierarchy. After all, these women have developed careers and strategies to maintain or advance these careers within a male world. The resentment of men may thus be a small or unimportant issue to such women. The questions of developing common purpose and social solidarity across professional and occupational lines on the basis of "sisterhood" is clearly a far more difficult problem. Nonetheless, the extent feminist ideology does provide the material for reformers in this area, and the rationale for practicing--and preaching--this gospel of sisterhood. Additional help may come from women's organizations that, once integrated within some region, institution, and specialty, show willingness to form coalitions on an ad hoc basis with women's coalitions and networks, joined to work toward a common goal, has already been discussed. The victories are not yet overwhelming--as the delay in passage of the Equal Rights Amendment so clearly demonstrates. Nonetheless, the principles and practices of coalition formation (and their interconnection of greater and greater numbers of networks) are accepted by more and more women's organizations. The recent growth of the Women's Action Alliance and the Women's Agenda give some indication of the potential power of a group to which such unlikely partners as the Association of Junior Leagues of America, the League of Women Voters, and gay rights organizations give their names as sponsors. If such diverse groups can see the potential in feminist networks, may we not hope for the same from women in the health sciences?

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FOOTNOTES

[1] See Becker, Howard S., Blanche Geer, Everett C. Hughes and Anselm Strauss, Boys in White, Student Culture in Medical School. Chicago: University of Chicago Press. See also Rue Bucher and Joan Stelling, in their recently completed comparative study of the socialization process among graduate students and residents in medical training programs. Sage Publications, in press. Other work in progress includes that of Rachel Kahn-Hut, San Francisco State University, comparing the development of a professional self-image in psychiatry and law.

[2] Recent evidence suggests that in fields where the number of women professors is greater, more women get through, get fellowships, assistantships, and good first placements. See e.g. Graham, Patricia Albjerg, Women in Academe. Lexington, Massachusetts: Xerox College Publishing, 1972; Rossi, Alice and Ann Calderwood (eds.), Academic Women on the Move. New York: Russell Sage Foundation, 1973.

[3] Yokopenic, Patricia A., Linda Borque and Donna Brogan, "Professional Communication Networks: A Case Study of Women in the American Public Health Association." Social Problems, 22, 4, April 1975, pp. 493-509.

[4] My own experience as editor of Social Problems suggests the cumulative effect a woman editor can have upon the publication of articles by women. During my term as editor, the number of associate editors who are women and additional outside referees more than doubled. Both the visibility of an editor known to be interested in encouraging women social scientists, as well as in the development of new research about women's issues, encouraged a high rate of submissions from women. While only a small number of articles ever received are appropriate for Social Problems (the journal only publishes about ten percent of all submissions), the high quality of some women's submissions and their eventual publication encouraged still others to submit. The interest from editor and associate editors in discovering the best of the new research on women has also encouraged development of this new area by showing how valuable this new research is in the growth of the discipline at large. The publication of new research in a learned journal serves both to encourage further research and to validate that already published. Thus women editors encourage the appearance in learned journals of articles authored by women or about women's issues.

[5] See Daniels, Arlene Kaplan, "Affirmative Action: An Exercise in Sociology of Sociology." The American Sociologist, 1974, for discussion of how difficult it is to meet affirmative action goals while following the old established methods of recruiting.

[6] See e.g. Carden, Maren Lockwood, The New Feminist Movement. New York: Russell Sage Foundation, 1974; Freeman, Jo, The Politics of Women's Liberation, New York: David McKay Company, Inc., 1975.

WHY BE A ROLE MODEL
WHEN YOU CAN BE A MENTOR?

Florence P. Haseltine

WHY BE A ROLE MODEL WHEN YOU CAN BE A MENTOR?

Florence P. Haseltine

Role modeling as an ideal has been proposed as a solution to the problems young women face when they look towards their future. What was conceived as a possible valuable socializing force may be a standard social putdown. It should be examined as a social dinosaur in the same way that the model of superwoman is being relegated to antiquity. Mary Rowe and I will examine the problem from two points of view: that of a senior woman trying to understand how to help, and, then, some concrete suggestions.

There is an obvious vacuum of women in power and leadership positions in medical schools. There are a few women in positions of academic responsibility and many of them are young and on the lower rungs of the academic ladder. The new women have had to chart their own course, very often with little idea of how to do it and most of the time without counselling, advice, and encouragement. The women have been self-driven and could be classified as overachievers. It is a bootstrapping operation, at best, and women should be alerted to power mechanisms that exist so that they can use them to get ahead and to control their own destinies. One idea that has been proposed is the finding of role models for young women. It is discussed as a positive role and young women are encouraged to look for women who set a pattern they would like to follow. But is it a solution or is it even helpful? We would like to show how it can be destructive; that role models actually may be inhibiting women's advancement. We would like to change the concept and involve women in the mentor system. But, first, let us consider the implications of a role model.

The first problem with relying on role-modeling theory to help advance student women is that the chief role models available for women in school are low paid, often exploited, clerical women, laboratory assistants, and relatively poorly paid teachers. If we have to rely on modeling theory, we will remain forever at the bottom of the ladder. There are not enough senior women to begin to counterbalance the omnipresent "models" of unpaid homemakers and poorly paid service professionals. Thus, role modeling may be destructive. It may actually teach young women to take and keep low paying jobs rather than to continue to seek appropriate renumeration and advancement.

Secondly, young women are examining their options and thinking ahead to when they will be practicing physicians. If they look at older women ahead of them to guide them, they are often disappointed in what they see. One will seldom find a person who exemplifies the kind of life she wants to lead. Either she will find that the people have unsatisfying social lives or unpleasant working habits. The negative aspects are always emphasized, so the people are trapped into being negative examples.

The other major problem that I see with role modeling is that times change. For example, when I was a student, only eight years ago, women medical students could ask the question, "Can I be a doctor and have a good personal life?" They had to work just to be in medical school and had no emotional energy left for this kind of question. I remember being very angry at young men for even asking the question. I would always challenge them with the statement - if they did not want to be doctors, what were they doing in medical school? I knew women who would gladly take their place.

Now that women are entering medical school in such large numbers, they are asking the same questions that the men have had the luxury to ask for years. How am I supposed to be a role model for someone who wants to know how to have a rewarding personal life and prevent the work from interferring with it? I always asked the question the other way: How do I prevent my personal life from interferring with my work? Academic women cannot be used as role models by the great bulk of students, who will go into practices completely disconnected from the universities. I very much wanted to be able to make my own choices, so I feel that younger women should be able to, too. There are just not enough senior women to take on the kind of task that being a role model requires. Academic women can be leaders in encouraging women to expand and to educate themselves to the possibilities that exist for women outside of academia. In this way, we may affect change in the treatment people receive when they interact with the medical establishment. A power base that extends outside of the university is much more solid.

We do not want to be role models. It becomes more and more evident that the term "role model" is an infantile and degrading term. It is an expression I had not heard since I was 10 years old when I was told to be a good example for my siblings. When I started my new job, I was told that I was now a role model. It was a strange experience. The people who said this were trying to make me feel good and certainly did not mean to be unpleasant. But until this job, I had been struggling to keep my head above water; now I had to take a deep breath and dive in again - with the knowledge that everything I did and said was under observation. Needless to say, that is offensive. If I am a role model, then I would like to have some say in the matter of how I am to be a woman for all seasons. I was being warned that I was being watched and carefully scrutinized. I felt that this appraisal was not reasonable. If I did a procedure differently from my colleagues, I was told I was not a good role model. It became a way of putting me down. There must be a better way of using my female presence other than being an example.

People from between 21 and 26 years of age are the main ones needing good help and prodding. That is a particularly difficult period because identities are being jelled and education is being completed. There are so many major problems to be dealt with that looking ahead to a brighter prospect is inevitable. Many of these people want to live "full lives." They revel at the compromises that have been made by those that could be role models, so we should try to get a different perspective on the utility of a professional woman.

A different task can be assigned to an academic woman - that of mentor. Most, if not all, successful males have had a mentor, but very few women have had them. Gail Sheehy in Passages describes how important mentors can be. I remember men having mentors and thereby getting the direction and guidance I clearly yearned for. I remember when a male was told to "publish or perish," but a woman knew she would publish and perish. I also remember that the men I knew who had mentors were very nice people and that exceptions were always made for them. The first time an exception was made, I felt I should not be angry about it because the man was not an evil person. But by the third time it happened, I knew it was unfair. It was unfair because these people were going to advance and they knew it. Now if these people were going to succeed when they were not qualified - that would have been discriminatory. But these men only succeeded when they worked. Mentor or not, those that did not produce fell by the wayside. The guidance these men received was valuable and gave them a sense of security so that they could work. Women had to produce, but never felt they were receiving help and encouragement from those ahead of them.

We should learn, from these obvious examples, how to help women get ahead. Being a mentor frees a person from being an example; it allows much more individuality of growth and minimal interference with people's values. The main job women as mentors should have is knowing what is available and always thinking of a name when a job is offered. This implies the creation of a type of group mentality which has not existed among women. Women who have made it are not always very helpful. But how can they be? Knowledge of how to help others coming up was not part of their consciousness. Furthermore, many women who have made it under isolating circumstances cannot give to someone else. The new young women are very threatening because they do not have to devote all their energies to their work to get the job done. But if successful women are going to take advantage of newly found opportunities, they must be involved with helping younger women. If they are able to say, "I will help you get what you want and not be what I am," they will be more influential.

The women in positions to help have to understand the system they are working in and that requires acknowledging all the things they must instinctively know from years of making it on their own. It requires a new level of consciousness-raising. The anger at not having control and being dictated to can be directed into other channels. Anger is there because the action is not. For the women in the establishment, I propose that the energy devoted to anger be devoted to promoting other women. To the younger women - I propose they find a mentor and make her work.

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GO HIRE YOURSELF A MENTOR

Mary P. Rowe

GO HIRE YOURSELF A MENTOR

Mary P. Rowe

One of my major bits of advice for all women in nontraditional environments is to find themselves a mentor. A mentor can be of any race or sex or age. You do not have to like him or her; therefore you have a wide range of people to choose from, including both pleasant people and those you consider to be dinosaurs.

Often young people are told to find role models, preferably same-sex, same-race, likable ones, hopefully of the same sexual orientation and value structure. One is told to find this saint and then learn to be like her or him. Saints, however, are few, (especially same-sex, same-race, etc. ones). Therefore, it is easier to find a mentor. Even a dinosaur can be encouraged to be a mentor, just so long as she or he is competent.

A mentor is a person who comments on your work, criticizing errors and praising excellence. This person sets high standards and teaches you to set and meet high standards. A mentor teaches you how The System works. If you are in a hospital, or in industry, you learn the organization chart and also how the place really works. If you are in academe, you learn the organization chart and also how the place really works. Most important, you learn how to succeed in your studies, how to succeed in your work, how to get promoted.

Mentors teach you which intellectual problems are important and how to recognize them yourself. They apprentice you to proposal writing, conference presentations, resume construction. They introduce you to important networks, talk about your work to others, and find you jobs. Initially they are your evaluators and the linkage to other evaluators. They teach you finally how to set your own goals, how to evaluate yourself realistically and how to succeed.

Many women find it hard to acquire a mentor. Senior women are exhausted and occasionally jealous of their uniqueness. Senior men sometimes ignore women, or they advance on women as sex objects. Or they avoid women because they are sex objects and wives would complain. Junior women are often shy. What to do?

Nearly any competent person can be helped to become your mentor. I mean this of course, not in the Machiavellian, exploitative sense, but in the context of respectful, honest behavior on your part.

1. Take responsibility for finding a mentor. Introduce yourself; make the first contact - always on a professional subject. Go up after class, write a letter with a question, comment on his/her last article, send your articles to her/him in draft, for comment.
2. Do it again, respectfully and intelligently.
3. Begin to ask for help about your errors and excellence. Cherish the good advice you are given and tell your mentor how helpful she/he is. Say it even if she/he brushes it off or says "It was nothing." Too few people say thank you; most people only complain about grievances. Be sure you acknowledge all the help you are given.
4. See if you can apprentice yourself, as a research helper, teaching assistant, junior collaborator, proposal writer.
5. As you get to know your mentor, be friendly, open, and very professional. Get to know her or his spouse; introduce your own friends. Avoid sex with a mentor at all costs unless you plan marriage or are so good that nothing can hurt you. However, if sex does become part of the relationship keep yourself independent. If a lot of work is accomplished make sure you get credit for it, and try to be independent enough to move to another city to advance if necessary.

6. Ask advice about your career advancement. Be cheerfully careful to express your appreciation for every decent thing your mentor does. (Most competent professionals live in an inhuman environment and really appreciate decent behavior).
7. Do whatever you can to help your mentor forever after and give credit in public for the help you have gotten. This reinforces good behavior everywhere. It will encourage you to become a first-rate mentor. With care and practice, you may even become a good role model for mentors.

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RECONCEPTUALIZING LEADERSHIP:
LOWER-STATUS WOMEN AND THE EXERCISE OF POWER
IN HEALTH CARE SETTINGS

Virginia Olesen

RECONCEPTUALIZING LEADERSHIP:
LOWER-STATUS WOMEN AND THE EXERCISE OF POWER IN HEALTH CARE SETTINGS

Virginia Olesen

To understand how women might exercise power and authority in health care leadership positions where they are now less than minimally present, it is useful to explore certain characteristics of organizations which particularly impinge on leadership, examining how those features might influence women's perceived competence as leaders and which might shape the success or failure they earn in such roles. Such an exploration moves beyond examination of the necessary recruitment of women to analysis of the critical questions of performance, achievement, and retention of women in high positions. To accomplish this, this paper will consider the position of women who do not exercise legitimate authority, who are not leaders in the formal sense; in short, the many women in the lower ranks of the American health and healing enterprise. It is a sociological truism that the professional person's freedom to exercise authority in an organizational setting is someone else's bondage, in this case that of lower-status women. Hence it is important to understand those features of organizational life for lower-status persons which bear on the exercise of leadership, which make authority possible, and which support those women who assume roles at the top. In short, a reciprocity of perspectives which takes into account the view from the bottom, as well as the top, is in order.

Sex Role Composition in Health Fields

Viewing the composition of the health fields, it is dramatically apparent that jobs which would not be defined as leadership positions, though they are crucial to the functions of health and healing systems, are largely staffed by women, some sources even say as much as 82.5 percent of all service workers (Navarro, 1975:5) in the health labor force. The following table makes this more explicit:

TABLE 1
Percentages of Women in Selected Allied Health Occupations
April 1, 1970

Occupation	Total Men/Women Employed	Percent of Women As Percent of Total
Dietitians	40,131	92.0
Therapists	75,161	63.3
Technologists & technicians Clinical laboratory	117,606	72.0
Dental hygienists	15,805	94.0
Health record	11,164	92.1
Radiologic	52,230	67.9
Therapy Assistants	3,211	66.0
Health administrators	84,139	44.6
Dental lab technicians	26,608	22.6
Opticians, lens grinders & polishers	27,380	22.3
Dental Assistants	88, 175	97.9
Health aides	118,907	84.6
Lay midwives	675	79.6
Nursing aides, orderlies & attendants	717,968	84.8
Practical nurses	237,133	96.4

(This table is adopted from Table 53, Number of Persons Employed in Selected Allied Health Occupations in the United States, by Sex: April 1, 1970, p. 58 in Minorities and Women in the Health Fields, Applicants, Students and Workers, U.S. Department of Health, Education and Welfare, Public Health Service, Health Resources Administration, Bureau of Health Manpower, DHEW Publication No. (HRA) 76-22, 1976.)

Since female students made up 89.1 percent of the enrollments in health occupations training programs administered by hospitals in 1973-1974, training for some positions noted in the table above and for others such as unit clerk, respiratory therapist, operating room technician, etc., large numbers of women will continue in these positions for some time to come (DHEW, 1976). Even in nursing where possibilities do exist to move up into leadership positions, e.g., ward supervisors, directors of nursing service, public health administrators, most nurses hold staff rather than supervisory positions. In hospitals, for instance, about 56 percent of registered nurses are general duty or staff nurses (USDL, 1975:153). Few nurses become hospital administrators, a post which seems beyond even female physicians who number only 1,000 out of 12,000 physician-administrators (U.S. Bureau of the Census, 1975:75).[1] When coupled with figures indicating few women in leadership jobs, these distributions showing large numbers of women in lower-status positions underscore again the lack of women in positions of leadership and authority.

This large pool of women in the lower positions, many of whom are minority women, needless to say, would be a prime resource for training capable and competent women who could enter training programs geared to leadership roles, wherever found in health and healing institutions.[2] Retrieving some of these women, the talented ones who are otherwise lost to the exercise of leadership, is an issue which demands full discussion elsewhere to determine policies for full utilization of women's talents and experiences wherever found.

What can be discussed here are two features of organization life in the context of health care settings: the implications for women in leadership positions and the presence of large numbers of lower-status women in those settings, women whose work performance will be crucial to the success or failure of the role performance of the woman in authority, and the general process of dissemination of information in an organization, a process in which both lower- and higher-status women participate with crucial consequences for both .

Women Working With Women

Presently the literature on women's relationships at work with other women is scarce, and where it does exist, is cloudy and diverse. Some reviews and findings, however, do offer some speculative leads. Kanter's recent analysis of woman and the structure of organizations presents useful information on two conditions, women working in all-female group and working conditions in a mixed-sex group (Kanter, 1975:60). This review notes that with respect to the all-female group "groups of women differ from groups of men primarily in orientations toward interpersonal relationships and level of aspirations," a finding which she interprets as a realistic response to women's structural situation, e.g., the limits on opportunities, women's generally low status, etc. These would be crucial considerations for a female supervisor or leader to take into account in assigning tasks, understanding what might seem to be lack of motivation for ascent in such a group and generally exercising authority for such a group.

This picture understandably changes when the work group becomes a mixed-sex group where such factors as frequency of participation, leadership, conformity may reflect such differences as status and power more than sex-linked personality traits. Kanter also points out that women and men, though defined as "peers" in a mixed group, may not be equal at all. The responses of women in such a group to the female supervisor may be very complex, indeed, influenced by these internal discrepancies, relationships with peers, implicit structures within the group.

The literature on women at work, as well as much of everyday life, makes it clear that both males and other females view women in leadership positions negatively. Repeated studies reveal that women prefer male supervisors to female supervisors, and even women leaders themselves, in a study reported by the Harvard Business Review, stated that they would not feel comfortable working for a woman (Harris, 1972; Kanter, 1975:60). These findings, coupled with the materials that show that some successful women discriminate against other females (Kieffer and Cullen, 1974) point to some of the difficulties which lie ahead for the woman who moves to a position where she supervises other women. In passing, it may be noted, too, that the so-called "fear of success," or "the motive to avoid success," though measured in populations other than women leaders, may well be related to ambivalence about these perceived feelings concerning women leaders.[3]

Thus, discrepancies between the taken-for-granted order of male dominance and female submission in American society which exist in the presence of female supervisors exercising authority over other females, even when the supervisor also can claim professional dominance, as with a female doctor, are such that strains ensue for all concerned in health care settings where this is the case. Not the least of the problems may be that the female in the leadership role may well be taken for a lower-status female worker, or that the female supervisor has real or imagined difficulties in the exercise of her authority. However, since some research suggests that women's negative attitudes toward other women are not universally held (Goldberg, 1974), it appears crucial to do the investigations which would clarify the circumstances under which negative or positive views are held of women supervisors by those supervised.

These questions and the hints of information contained in the sparse available literature appear answerable and understandable if we ground our inquiries in specifics of health care settings, where, in concern with those anthropologists whose work on women, power and structure has much to contribute (Collier, 1973). It would be very important to attend carefully to the situated activities of female leaders and others to ascertain what those activities mean to the participants and from those meanings what ideologies, cultures and structures come into play. For instance, it cannot be assumed that leadership means the same to all women working in the health fields and that success is necessarily tied to administrative ascent for all women (Lewin and Olesen, 1977), nor can it be taken for granted that the realization of equality in certain health care settings would be desirable for all participants (Nelson and Olesen, 1977).

The Social Distribution of Knowledge: Structural Aspects

When we think of types of knowledge in health care settings, we conjure up a very wide range of facts, opinions, interpretations, professional expertise, mundane formulas on dealing with the situation.[4] Moreover, we also have knowledge on how we know what we know, e.g., at first hand, by hearsay, etc. Though we usually assume that there are differences in what others know both in terms of facts and how they know it, learning how each person's stock of knowledge differs, hence learning the degrees of clarity, distinction, familiarity and precision in others' knowledge is an important, if unrecognized task for everyone in the setting (Schutz and Luckman, 1974:321). Needless to say, the boundaries of what is known are not coterminous with roles in the setting nor do those boundaries necessarily reflect the setting's hierarchy. For instance, it has been commonplace on back wards of state mental hospitals that nursing staff know a good deal more about patient conditions, response to medications, the operations of the ward than the physicians with the formally delegated authority to run the ward and prescribe for the patients. These observations are not particularly startling, but they become crucial when we recognize, as is apparent from our own experience and from a number of sources, that health care organization in the United States grows ever more, rather less, complex. Proliferation of roles in the hospital perhaps best illustrates this, but the point can be extended to those care settings which started out with relatively simple organization and by virtue of growth, demands, regulations, changes in care strategies have become much more complex. As settings become more complex, new roles emerge, tasks are subdivided, work and responsibilities are dispersed in different ways, the structure is by definition altered, as is the distribution of knowledge. This distribution becomes increasingly specialized and inequitable (Schutz and Luckman, 1973:314-15).

Thus we can think of a typography of knowledge differentially located, the modes of distribution growing more complex as the health care system itself grows more variegated. (This point is vividly illustrated by looking again at Table 1 which contains a number of jobs not in existence as recently as 10 to 15 years ago, those positions, of course, being occupied by women.) From this somewhat static view of distribution let us look briefly at process.

Processual Aspects

As we attempt to acquire knowledge in a health care setting, unless we're going to read everyone's files, look at the carbons in waste baskets and view our fellow participants through one-way mirrors, we're invariably thrown into interactions with persons who have differing types of knowledge, who have different ideas about the knowledge they have, and different ways of dispersing it. In more general terms, as persons continually seek knowledge in health care settings over a number of issues or problems, the parties to the search for knowledge come to typify one another and themselves to themselves. There begin to emerge certain highly specialized "careers" in the setting which reflect elements of this search and those who have the knowledge to dispense or not dispense as they see fit. "The inside dopester," "the information specialist," come into existence and become crucial to those who are in authority, since they often know more about certain features of the setting than the formally designated leaders: secretaries who know clinic files better than physicians know the patients, aides in public health settings who are more familiar with the vagaries of nurse practitioners than physicians, administrative assistants who know complexities of budgets far more precisely than clinic directors.

Another specialized role which can emerge as the processes around the distribution of knowledge go forward is that of the "opinion leader." Though this concept has most often been used in studies of mass communication, it is particularly apt for analysis of large, complex health care settings, such as hospitals where large numbers of lower-status participants have a part in patient care, communicate extensively among one another, and who sometimes define themselves as more capable of good patient care than professional nursing or medical staff (Simpson and Simpson, 1960). Thus, the influence of an "opinion leader" may well figure in issues of patient care, even though that opinion leader is not formally charged with that responsibility.

We should note, too, that along with the greater length of service which frequently characterizes lower-status participants in a health care setting as against shorter terms for highly mobile professional staff charged with responsibilities for exercise of authority, another factor influencing the emergence of roles in the distribution of knowledge is the greater mobility enjoyed by lower-status persons in some organizations. Like detail men in the drug industry or book salesmen in the academic world, lower-status persons who move from ward to ward, clinic to clinic often not only carry bits of knowledge, but themselves become highly knowledgeable, hence resources for information and knowledge not necessarily available to those in authority.

What can and does occur then is the emergence of a role structure tied to the social distribution of knowledge which may or may not be congruent with the organization's formal, authority structure. Where it is not, the discrepancies may pose genuine challenges to those who are in authority, particularly since it is not easy for those in leadership to have the same access to certain types of critical information as do knowledgeable lower-status persons. For females in authority this may constitute yet another discrepancy beyond those of sex role and organizational status noted earlier. Even where the structure of roles implicated in knowledge is more, rather than less, congruent with the formal structure, those at the top are frequently dependent on lower-status persons for specifics of situations or lines of action of which they have no knowledge, imperfect knowledge and no way to obtain the knowledge. Thus, the image of bondage which we noted earlier in the paper is reciprocal, the higher-status leader being as much in bondage as the lower-status individual is. Since the exercise of power is related to reciprocal dependence, we can begin to understand the comment that "it is not unusual for persons to leave bureaucratic organizations because of their inability or unwillingness to cope with the power of lower-ranking personnel" (Mechanic, 1968:425).

Power, Knowledge and the Negotiated Order

What has been described here as the processes in the distribution of social knowledge in health care settings are the processes of the negotiated order (Strauss, 1977). The interactive exchanges not only construct knowledge, e.g., definitions of what each person sees to be the case in the situation at hand, but those constructions in turn create structure and realities, as well as identities. In short, social life in the health care setting, the organization of the setting itself is continually created (Berger and Luckman, 1969).

Yet another element arises concerning power in the search for knowledge in the processes of exchange. As Nelson has noted, there is a notion of power implied in the negotiated order, that power being the potential for levying "the capacities for creating possible lines of actions for others as well as for oneself (Nelson, 1974:553). Those capacities are crucially predicated on the stock of knowledge, for instance, in a hypothetical well-baby clinic where pediatric nurse practitioners suspect an outbreak of infectious hepatitis, but closing the clinic to avert further infections are truncated. Indeed, those capacities may also be contained within the knowledge itself, for instance, again in the same hypothetical clinic, a report from the pediatric nurse practitioners that a number of children have colds provides a different type of knowledge for action than the report that a staphylococcus infection has appeared in the clinic. The latter information would demand much more immediate and forceful action from the clinic director than the former, but, again, if neither piece of information were conveyed to her, her capacity for action is blunted.

It should also be observed that a crucial feature of the negotiated order is the exchange of knowledge, knowledge thus becoming a kind of coin of the social realm, valued and evalued, bad sometimes driving out good. Those who have more knowledge to exchange will open more lines of action for themselves and others, if they chose to exchange their knowledge, will create more dependence on themselves, will exercise more power.

These features of the social distribution of knowledge and its relationship to the negotiated order also appear related to what has been called "the sentimental order" in complex organizations (Amir, 1974), those arrangements of affective ties among and between persons as differentiated from honor or prestige accorded to the position. The sentimental order is related to the negotiated order through the processes involved in the social distribution of knowledge because the interactions in the search for and dispersal of knowledge necessarily involve what Simmel has called the individualized, personalistic, idiosyncratic aspects of social existence (Simmel, 1959). While these aspects of social life are in play in transactions where knowledge is not at issue, it appears to be the case that they play a larger part in the exchanges around knowledge precisely because the distribution of knowledge is not formally congruent with the authority structure of the setting, hence more personalized strategies are necessary in order to seek and obtain knowledge.[5]

To summarize these comments about the social distribution of knowledge, the interpersonal dynamics which produce the negotiated order also produce a role structure in which relative expertise in knowledge is crucial and a sentimental order in which affect is distributed. These latter two orders may not be congruent with the formal structure of authority in the setting. The creation and dispersal of knowledge is crucial to action, hence where it is held by persons other than those in leadership positions, the exercise of power becomes problematic.

Implications for Women: Leaders and Led

What then are the implications for women in health care settings and systems?

It seems obvious enough, if the preceding discussion reflects any realities in the world of health systems, that it is crucial for women who aspire to and arrive in leadership positions to sense where knowledge is held, who generates it and to work with those lower-status persons, mostly women, who have it. Implementation of the best ideas imply action by leaders which in turn mandates the skillful acquisition and handling of information and knowledge. Recognition and utilization of the social distribution of knowledge and the corollary features of the sentimental order appear to be *sine qua non*.

However, a more fundamental issue may be noted, that related to the several meanings of the title of this paper. Thus far in the history of American health systems, few women, as has already been noted, have achieved positions of leadership. There are therefore a series of problems for women to whom authority is granted: networks of support and assistance may be non-existent and have to be generated, the socialization processes in learning the exercise of power may be imperfect. These may well be realizable only in the utilization of and participation in the interactive exchanges as the search for knowledge proceeds. Thus the social distribution of knowledge, presenting as it does the potential for successful activation of capacities for action by women leaders and those others in the settings where they are, also is crucial to the socialization of women in the new role of exercising authority and leadership. It is critically and crucially in the exchanges around knowledge that, as has already been noted, typifications of self and other occur, and where the forging of the type of leadership role which the woman will hold occurs.

Lenney has noted that "in achievement situations in which unambiguous performance feedback is not available, women report lower level of self-confidence than men, "a finding which suggests the critical nature of information and communication with other women for women new in leadership situations. Women's self-esteem and confidence in such instances may well be implicated (Lenney, 1975). Indeed, one might even hazard the inference that the woman who becomes a "charismatic leader" in the health care setting, is the woman whose participation in the distributive processes of the search for knowledge has resulted in a fine blend of sentiment and structure.

This also means that the socialization of women for leadership in health settings is crucially in the hands of other women: the secretaries, aides, clerks, technicians who staff such a setting. Structurally, roles occupied by these persons are the domain of women who take leadership positions; processually, persons occupying them accord women leaders the status of leader. If some of these lower-status women are, indeed, "inside dopesters," information specialists," "opinion leaders," their influence on the socialization of the woman as leader and on her enactment of leadership will be crucial. It would appear to be up to women who seek leadership and those who will accord it to recognize this and the fateful implications it has for the accomplishments of women in the new arena of leadership in the health fields.

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FOOTNOTES

[1] Additionally, less than 12 percent of the members of boards of trustees of reproductive and delivery institutions in health fields are women (Navarro, 1975:6).

[2] An additional pool, too, would be the host of clerical and secretarial personnel who staff offices, hospitals, etc. As elsewhere, most of the clerical force of the health manpower picture is female, 93.5 percent to be exact (Navarro, 1975:6).

[3] The literature on "fear of success" in women is vast, stemming from the seminal work of Horner (Horner, 1972). Readers are referred to Sex Roles, Vol. 2, No. 3 and 4, 1976 for an up-to-date review and critique of the concept and recent work on it.

[4] Only rarely has the issue of access to and husbanding of information in organizations been related to the exercise of power, one exception being the work of Mechanic (Mechanic, 1968). Similarly, women as lower-status participants generally have been ignored as exercisers of power, the writings of Nelson being a useful corrective to this lack of attention (Nelson, 1974).

[5] A personal example will illustrate: While chairing the Department of Social and Behavioral Sciences at the San Francisco campus of the University of California, I found that I could obtain extremely sensitive budgetary information, not only about the substance of the budget, but certain crucial information about "frozen categories," "penalties," etc., through reciprocal informal exchanges of personal and official knowledge, more easily than by administrative fiat. The latter strategy frequently wasn't effective at all, though theoretically in terms of legitimate authority, it should have been.

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V

FURTHER BARRIERS TO MOVING UP

In addition to the obstacles created by the informal and formal organization of leadership and authority in the health care professions, attitudinal and behavioral barriers exist within specific settings which reduce women's motivation and ability to advance.

Rowe describes how the minutiae of sex and race discrimination restrict women's mobility in many formerly unrecognized ways. Shapiro outlines the types of nonactionable discrimination that professional women face in training and practice and offers suggestions for counseling victims of such discrimination. Bourne considers some of the conflicts and contradictions in gender stereotypes and gender-role expectations that women medical students confront based on interviews from her URSA/WAP study. Lewis uses the case study method to illustrate typical affirmative action complaints and their outcomes. West -- drawing on her research in communication patterns -- shows how informal interaction and conversation between men and women may play a subtle but significant part in the day-to-day experience of a sexual tracking system within the health professions.

THE SATURNS RINGS PHENOMENON:

MICRO-INEQUITIES AND UNEQUAL OPPORTUNITY

IN THE AMERICAN ECONOMY

Mary P. Rowe

The examples of discrimination recounted in this study are all real incidents occurring during the years 1973-1976. This paper is a sequel to an earlier analysis called "The Saturn's Rings Phenomenon," (1973), and other 1975 articles on the minutiae of racism, inverse sexism, and sexism.

THE SATURNS RINGS PHENOMENON: MICRO-INEQUITIES AND UNEQUAL OPPORTUNITY IN THE AMERICAN ECONOMY

Mary P. Rowe

This paper describes some of the minutiae of racism and sexism in the American economy and schools. These minutiae are usually not (practically speaking) actionable; most are such petty incidents that they may not even be identified, much less protested. They are however important, like the dust and ice in Saturn's rings, because, taken together, they constitute formidable barriers. As Saturn is partially obscured by its rings, so are good jobs partially obscured for minorities and women, by "grains of sand": the minutiae of discrimination. This paper asks the question--Why look at "petty" incidents? It then briefly analyzes some "petty incidents" and raises hypotheses as to why and how such incidents may do damage.

I write today about micro-inequities and unequal opportunity for minorities and women at work and in school.[1]

What are micro-inequities? It will become obvious, from the definition that comes next, that each person is his or her own expert on what constitutes a micro-inequity in the individual instance. In the aggregate, I define discriminatory micro-inequities as destructive, but practially-speaking non-actionable, aspects of an environment. They are the instances which reasonable people would agree are unjust toward individuals, by virtue of an individual's being irrationally treated in a certain way only because of sex, race, religion, age, or country of origin. In studies of racism Dr. Chester Pierce calls many of these micro-inequities "micro-aggressions."[2] Jean-Paul Sartre has written about these phenomena as the expectations of anti-Semites about what it means to be a Jew.[3] Micro-inequities are of a fiendish efficiency in maintaining unequal opportunity, because they are the air we breathe, the books we read, and because we cannot change the personal characteristic which leads to the inequity. Micro-inequities are woven into all the threads of our work life and of American education. They are "micro," not at all in the sense of trivial, but in the sense of micro-economics, (which looks at the process and effect of decision-making at the level of individuals and firms).

The Extent of Inherited Unequal Opportunity

On what basis does one believe unequal opportunity persists? I allege unequal opportunity on the basis of grossly unequal representations of women and men, minorities and non-minorities, in the various areas of paid and unpaid employment, on the basis of wage gaps, and finally, on the basis of great differences in status between men and women, minorities and non-minorities, of a nature which cannot scientifically be explained by biological differences.

Consider for example, the statistics of unequal occupational opportunity. The proportions of minorities and women with advanced degrees in engineering, management, labor unions and national politics, is extremely small, less than 5%. Spokesmen of many disciplines will tell you "There are no competent women or minorities in my field." As we know, blacks and women in the paid labor force are generally found in only a few occupations: e.g. unskilled labor, nursing, clerical work, teaching, domestic work. Some may say these unequal distributions have occurred in part because of the different skills and interests of the different groups. Of course in part this is perfectly true, especially with respect to gender. Cross-culturally speaking, we generally find systematic occupational differences between men and women. On the other hand these systematic differences vary and are even reversed, from one society to another. Moreover, with respect to gender, the recent work of Eleanor Maccoby and Carol Jacklin[4] and James Harrison[5] make it seem extremely unlikely that innate psychological differences could conceivably explain the systematic differences in how men and women spend their time. Indeed Harrison's recent study argues strongly that the old masculinity-feminity paradigm has, scientifically speaking, caused confusion and damage, without any useful results for our scholarly understanding of these matters. The work of John Money[6] and Richard Green[7] again make clear how socialization patterns can "swamp" or over-rule genetic differences between men and women. I therefore believe that in an ideal "equal opportunity" world we would find men and women, randomly distributed by occupation, (paid and unpaid), and this premise will be found to underlie the paper.

With respect to race, it is also inappropriate to explain different occupational distributions solely in terms of biological differences. While a major social science battle rages about I.Q. differences between races, many distinguished researchers believe the argument for differences is based on questionable scientific grounds. Moreover, the relationship between I.Q. and career success is in any case very weak. Finally, as with occupational differences on the basis of gender, we find occupational differences by race to vary, very widely, from one society to another. One may thus hypothesize that in an "equal opportunity" world we would find people much more randomly distributed among occupations, by race, as well as sex.

Are opportunities getting better? In some fields the statistics are changing beyond the token level, for instance in law. But consider our slow national progress in college and university faculties during the so-called "affirmative action" years, 1968-1975. In 1968 some 19% of American faculty members were women. In 1975, fewer than 25% were women. The proportion of minorities has risen from about 2% to only about 4%. Few people believe that women or minorities have gained really significant ground in occupational desegregation in such areas as construction, national politics, or union management.

The wage statistics are for many people the worst indexes of unequal opportunity. White men working full time, year around were paid a median $9700 in 1971, black men $6700. White women were paid $5600, black women $5000. These wage gaps have been very persistent in the American economy even when labor force participation rates were changing fast; indeed recently the gaps have widened. Can these gaps be satisfactorily explained by educational differences? Some gaps still obtain, although not so grossly, when you control for education and years of experience. Many studies show that there are gaps left to be explained, even when all obvious factors have been taken into account.

Moreover just "accounting for" gaps is not the same as demonstrating no discrimination. For example some of the wage gap can be explained by occupational segregation: women and blacks usually take, or have to take, lower paying jobs. But it has also been recently demonstrated that some of the lower pay received by women is because certain jobs are designated for women and not because of lesser responsibility and productivity. That is, jobs sex-stereotyped for women are characterized by low incomes for both men and women in those jobs, relative to years of education and levels of responsibility. Secretarial work is a prime example of this phenomenon. In general the pay-off, to women, of a year of additional education, is about 2/3 that for men, (controlling for hours worked). Moreover, white females generally do not gain the occupational status of comparable white men. And a recent study[8] indicates that even with comparable parents and with comparable education, black females do not attain the occupational status of white females; black males do not attain the status of white males.

Why Does Unequal Opportunity Persist?

Instead of belaboring the point let me assume you are convinced that at least some unequal opportunity exists. How does all of this continue over time? Why don't civil rights acts and affirmative action take care of the problem? I believe that unequal opportunity persists in part because of early socialization patterns; for instance, many individual women are ambivalent about success (in ways that have been carefully studied).

Unequal opportunity also persists in part because of actionable discrimination that has not yet been acted on; one would expect, for example, to see many more Title IX and civil rights suits in public school systems in the next few years. I submit that unequal opportunity also persists in part because of the grains of sand in the system, the micro-inequities which cannot easily be taken to court. These grains of sand foul the processes of education and employment. It is hard to deal with micro-inequities because each one by itself, appears trivial. Because the victim finds it hard to be sure what happened. Because we are all so used to it, we don't notice. Because victims who are female and/or black are also socialized not to make a fuss, lest they get sacked or isolated or put down or called sick. I believe that the "tilt" in the atmosphere helps to explain some of the occupational segregation and wage and status differences referred to above.

In the past four years working on these questions I have seen or talked to or heard from at least 50 people a week--say 2500 problems a year. Of these 2500 problems and inquiries, probably 1000-1500 arise in some way out of discrimination. Lest you feel that in my saying this I believe that my own institution is relatively speaking in bad shape, I do not so believe. On the contrary (even bearing in mind my lack of objectivity since I care very much for the place), I find mine to be the least bad of large organizations I know of, which is a point perhaps to bear in mind as one reads the stories to come.

It also happens that I see and hear from hundreds of people outside my own organization; I include in this discussion examples of sexism and racism from such correspondents. I would like to emphasize that the incidents described below are from 1973-1976, and that all are true.

Micro-Inequities

Micro-inequities can be categorized in many different ways: ambiguous and non-ambiguous; spoken, written and non-verbal; repeated micro-inequities vs single incidents; problems with strangers, acquaintances, friends; problems with supervisors and other more powerful people vs those from peers and others; inequities met by people in traditional situations vs those met by people who are doing something unconventional.

Ralph Ellison used fiction to illuminate the minutiae of racism in every day living.[9] Chester Pierce, Margaret Campbell and Jean-Paul Sartre, have discussed micro-aggressions in terms of the media and institutions in which they appear, Martha Kent[10] in terms of certain common styles of inequity, Margaret Campbell also in terms of overt and subtle discrimination of various specific styles.[11] Rona Fields humorously categorized species of chauvinists.[12] Stephen Potter wrote extensively about intentional put-downs which have the purpose of self-aggrandizement; he categorized by degrees of hostility and type of situation.[13]

The incidents discussed in this paper are mainly those faced by minorities and women in paid employment and in training. My own concern is primarily how to deal with micro-inequities within large organizations. I have therefore classified incidents according to a judgment of the understanding and motivations of the perpetrators of inequities. One may deal differently with unconscious put-downs, exploitation and poor service. These latter problems in turn shade into more pathological inequities, many of which are sexist and racist manifestations of emotional illness. I think therefore, of micro-inequities existing along a continuum characterized by degrees of sensitivity of those responsible.

Unconscious Slights and Invisibility Problems

A minority woman came to see me for advice. She is a clerical worker, in a work-area where there are no other minority people and very few women. Her work has been progressing satisfactorily, in fact she thinks it is going well. But she is unhappy with her job--she's very lonely. In discussions about her unhappiness one day she said to me, "no one talks to me." I have heard many such stories, so I asked her, as I have asked many others before, to keep a one-week record. During that week no one from her area spoke to her at all. Other minority people from elsewhere in the university dropped in twice. None of her supervisors (who talked with each other a lot), met her eyes that she could recall. None of the men who came chatting past her desk addressed her by name, in the brief notes about work that were dropped on her desk. No one has thanked her for work done. Like many women she feels invisible. This particular saga is among the most frequent stories to come to our office. I recall a minority carpenter, a telephone company manager, a factory forewoman, a supermarket management trainee, and many professors and students who feel a surrealistic sense of being invisible on traditionally white male turf.

Women and minorities may become aware of their invisibility only slowly, because it happens only now and then and it is so difficult to identify. In the story of the clerical worker, this woman came to see me wondering what was wrong--she did not know why she was so uncomfortable and unhappy. We may come to believe we are invisible when our names are left off a list. Only one person is not invited to the supervisor's party--the only black. One person's vacations do not appear on the vacation list--those of the only woman in the office. One person's lunch hours are forgetfully not allowed for in a busy office--the woman's. It happens to people in all kinds of jobs. From three universities in this area come at least twenty 1973-76 stories of blacks and women whose names were left off faculty lists and who, therefore, were not invited to various faculty functions last year or who were not given credit in major announcements.

There is a distinguished visitor for whom a last minute special lunch is given; only the black research associate is not invited. There is another lunch; everyone is introduced around in the circle; only the woman, out of a list of distinguished guests, is not introduced. This year many female Boston students have come to see me. They say, "all the men in my department have been suggested for certain jobs," or fellowships, or post docs...only the solo woman was not counselled, approached or put up for jobs. Two of these women have said they inquired and complained. "We thought you'd be going with your fiance so we didn't put your name up for jobs 'til we knew where he was going" ...they were told.

We feel invisible sometimes with respect to the procedures which govern our lives. All over the country minorities and women ask to be named to the committees that govern their work lives, just as we ask to be better represented on the industrial and government bodies which affect and govern us--but we are often invisible once on the committees. Two colleagues, in different large corporations have told me recently, "I was the only woman on the large committee that determines maternity benefits and they never asked me to speak." In another organization, a study group is set up on family policy; yet another on child-raising in cities--neither has any black or female members. A major study is launched on inner city education--with no blacks.

Invisibility affects success at work and salary equity very directly. A woman staff person says "It's harder for me to keep up; mine is the only office to which the book salesman does not come." A large office in Boston had several minority women working in it--one of whom has a fine work record, a BA and five years experience. When a supervisor was needed in this office, a much younger white male with no experience in the area, was brought in as supervisor. Doing research on a particular salary problem, I found a recent article on "Black-White Wage Gaps." The article dealt only with men; minority and non-minority women were not mentioned. Major, meticulous, staff-classification studies (which look at job responsibility) regularly find that most of those deserving salary adjustments are female, and this will occur even when all salaries were previously carefully reviewed by men of good will. We find the invisibility phenomena in speech. We use the phrase "blacks or women." ("We hope we will find a black or a woman for this job"), without thinking that that leaves out black women. We find the same phenomenon often, in the way things are designed. Convention name tags are often designed to hang from a man's pocket; buildings are designed without locker rooms for women.

Unconscious slights are many. Women are frequently addressed by their first names by men who don't know them, or gently or roughly "herded" or patted by men who put an arm paternalistically around them; we are called "dearie" and "sweetheart." Here again, unconscious slights may affect salaries, promotion, job choice. We are hearing many cases like that of an able, female assistant professor, who asked for an average raise. She was told, "You don't need it; you're married. There's budget crunch and we have to save for people who need it. You do understand?" A black professor was roughed up by students. The university administration said "It's their word against yours; we can't prove anything." Later this man heard he was considered "contentious," although this was the only fracas he had ever been in. He felt unconscious slights were being added to the criminal attack upon him. I remember also several cases where black faculty and administrators with doctorate degrees were presumed to be still at work on a thesis and therefore not yet promotable.

Then there was the ad hoc committee at a New England university, which solicited letters in support of tenure for Jane Doe, a famous archeologist. Jane Doe came to see me, having received, from one of her referees, a xerox copy of his reference. It read, in part, "Dr. Jane Doe is probably the outstanding woman archeologist in the world." Jane Doe was deeply offended. I advised her to call the referee. He read her a sentence from the letter of solicitation, which said, "Would you tell us how this woman ranks among women archeologists?" It turned out that the standard solicitation letter had been sent out, simply changing the word "man" for "woman," in such a way as to ask for, and receive, nonsense recommendations.

Conscious Slights, Harrassment, Poor Service and Exploitation

Conscious slights can strongly affect motivation and job choice. I remember black students in a science course, for instance, who were called by humiliating nicknames and who simply left the course. Recently I met a woman student whose husband lived elsewhere while she finished her degree; she was very discouraged about some of the gossip: "Is she doing badly in that course because her husband is not with her? She ought to be home doing what women do best!" Another woman was asked to leave a class on the first day "because she cramped the professor's style." In many arenas there is a problem also of over-visibility where minorities and women feel they cannot be just average, or have an off-day without inviting hostile teasing. Some of us are afraid of put downs for being dumb in school or training courses, so we don't ask questions...and we don't learn enough. A union apprentice came recently to ask me what she should do; everytime she asked a question the men present would guffaw, in a deliberate attempt to humiliate her.

Other union women have described many instances where men would block their cars, "mislay" their tools, endlessly tie up showers, deliberately try to make work conversations derogatory, hostile and frightening to women. Several have described union stewards who will simply ignore their concerns or belittle them. Black and Spanish-speaking union men describe slashed tires, colleagues turning their backs, and many instances where co-workers have refused to help them on the job.

As I think of harassment, I remember a professor's lengthy shouting at a clerical worker. He was making the bland assumption that a minority secretary wasn't telling the truth about how some data got lost, when in fact the woman had been on vacation the week the data got lost. Women bring in a variety of incidents of tempers and shouting. We hear stories of the belongings of a black graduate student being moved without persmission, of supervisors going through a woman's desk or a union woman's locker without permission, of bosses' interrupting secretaries on the telephone. There are several instances where minorities and women feel they may have been deliberately put down by colleagues in a position to influence Federal contracts.

Many slights are explicitly oriented toward sex or race. There was the matron at a nearby school who was told her yeast infection was, "a venereal disease--who had she been sleeping with?" Another woman who was angrily warned not to "ask to get raped" by being out at night at a better job, and a third who was asked whether she was going to get pregnant soon, when she discussed her plan to go to Medical School. This last woman was also told she was a "bitch with no right to quit, who could have a great career as a technician if she 'really' was tired of typing for the lab." I remember the black who was told that his Southern schooling was inferior and he'd never make it up, and many instances of minority people being called names.

Some incidents are hard to identify from the point of view of the "consciousness" of the aggressors. A woman in a training course worked on a technical problem for a long time and finally went for help and learned how to deal with the problem. Later she met two men from her course, struggling with the same dilemma. She offered to help, with the method she'd been taught. They ignored her for a deeply frustrating hour while she watched, baffled and angry. Finally a fourth trainee appeared--a man. He also offered help--with the same method as the woman. His help was gratefully accepted; the woman was still ignored. I am not clear just how much the men understood of what was going on. I have heard, in fact, many incidents which seem very obvious but where the men do not seem to hear what they have said. There was the vice-president of a large firm whom I asked about the appointment of an able woman to be an operations manager. "I couldn't do that; she's black and a woman. She's not even pretty," he said off-handedly, but serious. I heard another man congratulate a distinguished day care expert on her forth-coming trip, "You must be enjoying the honor of going with Messrs, X, Y and Z," he said, naming her peers and co-workers.

Sometimes a formerly white-male environment or tradition means that minority and female students and employees get poor service in one way or another. Blacks and women may be so few in a given company that they cannot find enough contact with other blacks and women to make up for the casual scientific or technical chit-chat they are left out of, when it occurs in white male social groups. This can be very serious, as studies regularly show that informal teaching is very important, for instance in telephone company crafts jobs, or in teaching situations like the "scrubbing" before and after an operation, where women medical students may scrub with the nurses, and miss out on the informal teaching of a male surgeon. Poor service in recruitment frequently occurs; for example there have been several recent incidents around Boston of minorities and women answering Assistant Professor ads who were offered Lecturer and Research Assistant jobs with no explanation. Others have gone to give colloquia where no senior faculty appeared. I remember the recent case of a Spanish speaking mathematician who was asked to do all the programming for his team when he had been hired as a senior researcher.

There are many stories of exploitation - unpaid lunches, unrecognized research work, unpaid overtime. I just heard again from a research associate at a Massachusetts college who is paid $11,000 when her job should have been rated at $18,000; her salary will be raised but it has been a long fight. I recently met an apprentice electrician who worked overtime, unpaid, every night for weeks, finishing her bosses' projects. There is also the endless media exploitation of sex: medical school pornographic slides; the advertisement of an astrophysics book called The Black Hole which shows a slatternly minority women as a come-on.

Emotional Difficulties with Sexist and Racist Manifestations

I remember the black graduate student who came back from a lab in tears--she'd been told by her teaching assistant, when she came in with a bad cold, "Chick, what you need is a hot, deep protein infusion!" In that very large lab have been several women who will not take evening jobs for fear of rape--that quintessentially male disease which afflicts mainly women, and especially minority women.

Then there was the scientist who wrote me from a nearby university, "Despite the fact that women may be even more qualified, I believe we should curtail the admissions of women; they will deter men from doing their best creative work." There was a black student who was "hilariously" called by the last name of her advisor, for whom she was working; thus Susie Smith was "jokingly" called Susie Jenkins, because she worked for Professor Jenkins and "therefore belonged to him." She repeatedly asked the harasser to stop this but he persisted in thinking the situation was "funny," and continued. I was recently consulted in a case where a black researcher was let go for "ineffective work." It turned out that a woman had been blindfolded and raped and the one black in the building was presumed to have done it, but was not told this was the reason for firing him.

I remember the written reference given for a woman scientist, which I found in the files, "You can hire this woman for your lab if you want to, but I'd rather have her body than her mind." Casting couch stories abound still, in firms all over Boston, and appear to be if anything more frequent, as job insecurity grows. Many women recall very explicit threats: "Well, you know, I set your salary," and many more innuendos: "If you'll come on the trip with me, we'll see about promoting you to further responsibility."

Then there have been the occasional serious allegations of unequal rating and grading of blacks and women in jobs and schools. And the stories of men who go into deep withdrawals or rages, when faced with the need to communicate with female secretaries and students. There are the occasional men and women who flatly refuse to work with or for those of other races, who permit minorities to get into dangerous situations or who provoke accidents around those of other races, or who deliberately try to make them feel afraid or incompetent. There are the occasional men who expose themselves, who won't take no from a woman they want to date, who need to seduce women they see as competitive, who pick on handicapped women, who will deliberately and repeatedly lie to women, who deliberately try to arouse a women's guilt or worry about her family or femininity, who will smilingly say to a woman student, "I believe the only interesting thing about you is between your legs."

Where Do Micro-Inequities Come From?

I have presented random incidents from many hundreds of stories a year. One wonders, where does this behavior come from? Why does it persist? Sartre has written at length about the need of bigots to aggrandize at someone else's expense; the hostility and anger of one who discriminates "precedes the facts that are supposed to call it forth."[14] He further hypothesizes a need in bigots to blame someone (else) for the evil in the world. The discriminator "is afraid of discovering that the world is ill-contrived, for then it would be necessary (to be) master of his own destinies,"[15] to have to do something to make matters better.

Chester Pierce has hypothesized that discrimination develops as a syndrome from the practice of "childism": The systematic putting down of children and of aggrandizing at children's expense.[16] Brownmiller suggests that rape may be a fundamental paradigm in human behavior.[17]

I agree with the analysis of bigotry, and believe that in our culture the habit and perceived legitimacy of micro-inequities may indeed start with childism. I also believe that sexualization of aggression is frequent, whether or not innate. In a wider context, I think that "pecking order" behavior is ubiquitous and may be innate, but the form it takes is very malleable and sensitive to different socialization patterns and sanctions. I think of micro-inequities as a complex phenomenon which helps to maintain a pecking order, with respect to whatever group is being put down. I believe micro-inequities are at their worst where people are functioning in what is for them an unusual or non-traditional environment;[18] since "unusual" people are easy to pick out for the purposes of maintaining a given pecking order. If this is true, a good deal can be done to ameliorate micro-inequities by making "non-traditional" persons seem less unusual in traditional environments. However, before we plan amelioration, it is important to analyze what is the process of damage in the first place.

What Damage is Done by the Minutiae of Discrimination?

I know of no systematic study of micro-inequities, but one can suggest many hypotheses as to why such behavior does damage. Obviously, from my own point of view, I believe that these inequities do cause serious damage or I would not label them a major barrier to equal opportunity. I will therefore set forth my hypotheses:

·Micro-inequities cause damage in part because they often lead to yet worse behavior. Thus overlooking or "seeing through" blacks and women is a habit which may lead to overlooking one who might be the best qualified person for promotion. It may also lead to underpaying minorities and women.

·Micro-inequities cause damage in part because they are a kind of pain which cannot be predicted very well in any functional sense. That is, by and large, they occur in the context of merit, and of striving for excellence, but do not have anything predictably to do with excellence or merit; that is, of course, by definition what makes them "inequities." As an intermittent, unpredictable reinforcement, however, they have peculiar power as a negative learning tool (unpredictable, intermittent reinforcement being among the more powerful types of reinforcement). Moreover because the provocation for negative reinforcement--one's race and gender--cannot be changed, one inevitably feels some helplessness.

·Micro-inequities cause damage in part because they take up time. Sorting out what is happening to one, and dealing with one's pain and anger takes time. Extra time is demanded also from many minorities and women to help deal with the pain caused by micro-inequities suffered by other minorities and women.

·Some micro-inequities cause damage in addition to the direct pain inflicted, because as they occur they prevent better behavior from occurring. If a secretary or graduate student is unreasonably overloaded with routine or personal work for a supervisor, the overloaded person may suffer a loss of self-esteem and may also be prevented from doing the kind of excellent work that prepares one for promotion.

·Micro-inequities cause damage in part because they contribute to barriers between men and women, minorities and non-minorities, which mean that each group fails to understand what the other faces. The forms of racism and sexism are so specific that each group is isolated from the other's experience. Cross-group communications are always slower and more difficult; cross-group judgements are harder to make well. Thus women and men may make errors about each other ranging from paranoia to an inability to hear any criticism against individuals of a different sex. So also with minorities and non-minorities.

·Micro-inequities are often difficult to detect or be sure about. This means for one thing that these inequities are hard for a victim to turn off. It also means that frequent victims, like blacks and women, may constantly have to range through emotions ranging from legitimate anger (which may or may not have, or appear to have, a constructive outlet) to paranoia. The experience of being uncertain about whether one was insulted or put down inevitably leads to some displaced and misplaced anger which in turn may anger innocent (or guilty) bystanders. It also leads to ignoring real insults in such a way that they persist.

·Micro-inequities are often not intentional in any conscious or even unconscious way even when objective observers would agree that for sure they exist--that an injury really took place. This is another reason they are hard for a victim to respond to. We are all socialized to believe that intent to injure is an important part of injury, and it is certainly critical to our dealing with injuries at the hands of others. Faced with a micro-aggression, the victim may not be certain of the motives of the aggressor and may be unwilling to start a fight where none was meant. Under conditions of uncertainty about motives most victims are again in the position of sometimes not getting angry when they should (which perpetuates the injuries and may weaken the victim's self-image), or protesting sometimes when no injury was consciously intended even though it actually occurred. The latter situation can, actually, be salutary for all concerned, especially if the aggressor reacts by acknowledging an unconscious intent to injure. But sometimes the aggressor is totally unaware of aggressing, even though observers would agree that injury took place. The aggressor may then respond with anger, feelings of betrayal, bewilderment or worse.

·Micro-aggressions seem petty, in a world where redress by the less powerful may often seem heavy-handed or too clumsy a tool. Unionization, going to court, appeal to the President's office, may seem heavy weapons which themselves have high costs. The perceived lack of appropriate weights of redress help perpetuate micro-aggressions.

·Micro-aggressions and inequities grow in mad and infinite variety. It is hard to stay ahead of the proliferation of types, let alone the number of petty injuries. Thus most victims find themselves occasionally fighting the last war rather than the present one--that is to say, fighting inappropriately against some new variety of harassment.·

·Micro-aggressions of some types may have a negative Pygmalion quality. That is, the expectation of poor performance, or the lack of expectation of good performance, may by itself do damage because students and employees have a strong tendency to do what is expected of them. As Sartre noted throughout his book on anti-Semitism, the anti-Semite creates the Jew.

Do Micro-Aggressions Do More Harm to Minorities and Women than to White Men?

The question is frequently raised whether micro-aggressions do not just "happen to everyone?" Have we not just been describing the general inhumanities of large organizations? Quite frequently I will talk with a powerful white male who opening says, "I harass everybody, Mary. I don't discriminate." Let me raise here hypotheses as to why micro-aggressions might be worse for minorities and women than for the average white male. Some of the hypotheses as to why micro-inequities may do more damage to minorities and women are analogous to the hypotheses as to why they do damage at all.

·The "general" harassment often takes specifically sexist form when applied to women, or racist when applied to blacks. Instead of saying to some average white male, "Your work on this experiment has been inexcusably sloppy; you'll never make it that way!", the remark may come out, "My God, you think no better than my wife; go home and have babies!", or "We will never be able to make up for the generations of Southern schools that produced you!" The harassment of blacks piles up in allusions to race, the harassment of women as allusions to sex roles and sex, instead of being randomly applied, or appropriately focused on work. Like the dripping of water, random drops do little damage; endless drops in one place can have profound effects.

·Many minorities and women are socialized to respond disproportionately swiftly to disapproval. Their parents have carefully taught them to cooperate rather than to compete, especially when they are with white males, and to be very sensitive to anger and criticism from white males. Conversely one can find many white males who were explicitly socialized to expect hard knocks, to compete ferociously and openly even when injured, and to have a very high pain threshold in the first place. It would be hard to prove that either kind of socialization is "right" or "wrong" in absolute terms, but it is easy to see how these two cultural paths run afoul of each other. If a white male supervisor shouts angrily for five minutes at a young woman, she may not wholly "recover" from the attack for weeks or months or years. Later, in a discussion with the supervisor, however, one may hear that he's forgotten his "random grouchiness" or thought it was trivial. Thus, behavior that might be trivial or survivable for the modal white male may be quite destructive to others, in a manner that has nothing directly to do with the work at hand.

·Micro-inequities often originate with more powerful people against less powerful people. No one yet knows whether they originate more in this direction than in the reverse. Perhaps power is corrupting; perhaps aggressive underdogs are always eliminated over time or perhaps more powerful people ignore or are not injured by inequities from below. Perhaps the generally higher pay of the more powerful gives adequate recompense. In any case it is generally the less powerful who report inequities the most. Since less powerful people by definition have less influence and since more of them are black and female, it is not hard to see why it is difficult to get rid of micro-aggressors in general, let alone specific individuals who happen to be the victim's own supervisor or advisor.

·Traditionally white male environments may even support and reinforce certain kinds of discriminatory behavior like the aggressive and humiliating telling of dirty jokes, or racist or ethnic jokes, in a lab.

·In a traditionally white male atmosphere it may also be harder for bystanders to stop certain kinds of micro-inequities, because the slights are so normal that they simply are not noticed. Many white males are acutely uncomfortable around Orientals or blacks or secretaries; they ignore them or fail to look at and address them--but do not notice it and neither do bystanders notice it. Traditional pornography on walls, and traditionally racist and sexist jokes, and the use of sex in ads and announcements is so ubiquitous that probably most men do not notice them. Thus while some general forms of harassment and difficulty may be stopped by bystanders, some aggressive behavior may be overlooked because it is so "normal."

·There is a more acute role-modelling problem for blacks and women in non-traditional studies and jobs, with respect to their witnessing micro-inequities against others like themselves. That is, disproportionately more blacks and women see people "like them" put down or ignored or ill-served by their superiors and elders. This point may be clearer when one remembers that in most work environments, the principal (if unintended) same-sex and same-race role models for blacks and females are clerical workers and hourly workers, and that these are the groups most frequently reporting micro-inequities. This inadvertant role-modelling is the stronger because nearly all blacks and women are continuously being taken to be in jobs traditionally held by blacks and women. Thus the identity problem for blacks and women in non-traditional jobs is exacerbated by unconscious stereotyping. "I am constantly being taken to be a file clerk," says a black woman engineer, "I constantly feel a struggle to develop my own self image, but it is not affirmed by most of the world around me, as it is for my male colleagues."

·It may be harder for minorities and women to find mentors to help them deal with micro-inequities. There are so few senior minorities and women in most organizations that junior members of the community cannot, on the average, find the same amount of high-status, same-race, same-sex mentorship that white males can find. Sometimes the higher-status women and minorities try to compensate by spending extra time as same-sex, same-race mentors. It is, however, almost inevitable that the burden of dealing with micro-inequities falls on victims who are already somewhat disproportionately drained of energy by caring for others.

·There is also sometimes a peculiar difficulty in finding an appropriate mentor when one has been the victim of a micro-aggression. If one goes to a white male, he may or may not understand. If one goes to a friend of the same race and sex, he or she may be just wonderful in helping one to deal with it, or may not be helpful at all. That is, listeners of the same sex and race may be so discouraged and angry, or so full of denial, that they are worse than useless. I believe therefore that it may often be more difficult for minorities and women to find adequate help in dealing with racism and sexism, than for average members of the community to deal with "general inhumanities."

I believe many minority and women students and employees have a disproportionate need for supportive white male mentorship, and are disproportionately injured when an advisor or teacher or supervisor assigned to them is just generally inhuman. Let us take an example, Susie Hernandez, who is a student. She has a need for support if only because she will inevitably live through many micro-inequities. She needs someone to advise her about getting ahead in our white male environment because it is foreign to her. She may not be getting much support from Spanish-speaking women at home because she is living a non-traditional life. (She is in other words less well supported by the general society and may be less well supported by her family than if she were a white male.) If her assigned advisor turns out to be just generally inattentive, grouchy and cold, she has been deprived of a needed, positive mentor in circumstances where she needed a mentor probably more than the model white male student. The situation will be compounded if she is afraid to ask for a new advisor or does not know how to find substitute help.

I believe therefore there are many reasons why the problem of micro-inequities for minorities and women goes beyond the general inhumanities of large organizations. The point may be clearer if you will imagine being a solo, young, white, male childcare worker in a large, conservative, inner-city day care system. The "general harassment" might include sincere questions and snide comments on your sexuality. Other white males might find you odd. Women might distrust your skills. You might be in fact inept, in some ways, your first year. You might be very sensitive to run-of-the-mill anger from your cross-sex, perhaps cross-race, supervisor. You might find the constant assumption that women-are-better to be very oppressive--the ads, the jokes, the pictures on the walls, the fathers deprived of custody. You might have no one like yourself to turn to. You might get to hate always being asked to fix things and being asked by visitors why you are there.

In summary, I believe that discriminatory behavior itself causes pain, and also may constitute for minorities and women a situation they cannot control, evade, or ameliorate (or, as we have said, they may see it that way). Continued experience of destructive situations which cannot be improved can start unhappy cycles of behavior ranging from declining self-esteem (which makes one feel still less efficacious in changing the environment) to withdrawal, resignation, poor work, fantasies of violence, and so on. At the very least it either takes a lot of energy to deal with an environment perceived as hostile, or it takes lots of energy to maintain one's level of denial of difficulties. (I have known victims to struggle for days at a time with their profound anger at an apparently "petty" insult).

Are Micro-Inequities Ever Useful?

Occasionally one will find someone who believes that hardship is good for people, creativity requires incessant pain, harassment inspires excellence. Sometimes someone will say, "I made it through terrible anguish--so can everyone else."

It is hard to respond to these ideas because individual situations vary so much. The speaker who remembers having survived terrible anguish may also have had exceptional health and energy, or a wonderfully supportive parent or uncle or religion, or extended family--or may be the only person of his or her type ever to have survived that background--or may have come through terribly scarred.

I think most of us believe that challenge is good (in the right doses), that creativity requires intense concentration and effort, and that excellence and high expectations inspire excellence. Most people believe that intermittent positive reinforcements--that carrots--are more powerful than sticks. I do not believe our world to be so devoid of sticks that we need more of them. And there seem to me to be enough good reasons to believe that micro-inequities cause damage, that we should try to ameliorate them. The Law of Parsimony would suggest that it is simplest to assume that human ability is randomly distributed, and that we could therefore double the incidence of, say, excellent management and government, by equal opportunity for minorities and women. Is this not a sufficient incentive for us to try to undo any disproportionate damage that occurs? And is it not simpler to assume people survive in spite of damage rather than because of it?

What Is To Be Done?

The question of micro-inequities can be addressed at national, organizational and individual levels. My experience these last three years leads me to believe we can be at least somewhat effective, at all three levels, in relatively short periods of time.

At the national level, we need to communicate what we know, and find out more. For instance, recent discussions on this general topic have already produced serious changes in the process of higher education in many institutions. Changes in newspaper language, publishers' editing manuals, advertisements, and TV programming are beginning to be widely seen. Several unions have begun seriously to consider micro-aggressions against their members. Congresspeople say "him and her" now and then. School children are beginning to talk of these things with their parents.

We need more research. What are the relative micro-patterns of religious discrimination, racism, ageism, sexism, and inverse sexism? Are micro-inequities indeed more prevalent and/or more damaging for people working in nontraditional environments? How do micro-inequities occur in schools? In blue collar jobs? In professional work? How are they related to status, physical appearance, wealth? What do we know of micro-hostilities in different ethnic groups? Can we test the hypotheses presented above?

At an organizational level there seem to be three major resources for change: leadership by top management, grass roots groups, and an innovative grievance process.

The top administration needs to be the major source of male-to-male consciousness-raising, and anti-discrimination goal setting. I recall once when the all-white, male executive group of a large corporation was leaving a meeting. A sudden silence fell; an unfortunate sexist comment was widely overheard. A Yankee-Brahmin Vice President, himself only recently sensitized to sexism, drew himself to his full imposing height: "Gentlemen, I believe that is the kind of belittling language we need never hear in this firm again." There is no substitute for this kind of sturdy, consistent leadership, at the top and disseminated vigorously downward.

The other major contribution from top management is aggressive recruitment of minorities and women for the higher levels of professional work and administration. The best way for these newcomers not to "appear unusual" (as easy targets for the pecking order) is for them not to be unusual. I believe much of racism and sexism will disappear when minorities and women are randomly distributed throughout organizations of all kinds.

Grass roots groups of blacks, and Orientals, of the Spanish-speaking, and of women can be very effective media of support to each other. Many top managers are hesitant about these new employee groups; others have found them very effective. If managers can countenance the formation of many different groups, they may find a healthy diversity and communication springing up. Fanatics tend to get "cooled out," and responsible minorities and women are given leverage, in the many such groups I have seen.

There is no substitute for the work of such groups in illuminating abuses, problems, and progress for top management. (The better the company president, the less likely he or she is to know of discrimination in the organization; almost nobody misbehaves in front of a good president.) Variegated minority groups and women's groups can turn up thousands of small problems, and deal with them; the very presence of such groups tends also to prevent micro-inequities. I have repeatedly noticed a drop in the abuse level in various work areas, upon formation of a responsible group.

These informal groups speak to others of the concerns raised above, in addition to communications and consciousness-raising. Groups may foster a gentle rise in assertiveness. They tend to expand the effectiveness of healthy role models whom many minorities and women might otherwise not meet. They provide support, counsel, and a sense of reality to weary senior women and minorities and help them to become the mentors so sorely needed. They further provide a structure to support improvement on "macro" problems, like recruitment. Probably most important, they are a leaven for change to improve work and educational processes for everybody, male and female, minority and non-minority.

Innovative grievance procedures also help with micro-inequities. My own suggestions are several. I believe in mildly redundant procedures so each person has a greater chance for sympathetic help. I believe grievance procedures should handle "inquiries" as well as complaints. As many a union steward and supervisor knows, most inquiries can be dealt with in a way that prevents grievances by working on them early. I believe all but the worst grievances can be dealt with by mediation (seeking for common ground) rather than arbitration.

Informal, open communications at every level including the top can often handle problems at the seedling stage. A complainer or inquirer who jumps the formal channels will probably be sent back through the channels, but one can at least support people to represent their concerns more effectively and responsibly. Moreover, dealing informally, one often finds the complainant or supervisor has a hidden issue or problem, sometimes not even consciously understood. Sensitive support may help such a person to third-party help (for example, a minister, lawyer or physician).

This kind of grievance procedure must be dependably confidential at the inquiry stage. Even if keeping an inquiry confidential means that for a time no direct help can be given, sometimes a sympathetic ear itself will help; many people simply need someone to listen.

People involved in grievance work must be scrupulously careful about the equal protection of everyone's civil rights. Perhaps it would be good to have an aged, handicapped, minority, Jewish woman as ombudsperson; it is obvious that aged, handicapped, etc. people will feel more free to go to such a person. In dealing with sexist and racist micro-inequities I think it is necessary for the grievance process to include women and minorities. However, such people cannot act as advocates in their grievance work. Advocacy belongs with the minority groups and women's groups; a passionate committment to objectivity belongs with the grievance process.

I think it helps to have a universal grievance process which deals with every pay classification and all levels of students and trainees. Macro- and micro-inequities are often very complex, involving many different people and/or needed resources. It is helpful to see problems in the real-life web in which they actually occur. And one universal process is much more easily understood and communicated.

How can we work with individuals, to help them help themselves not to be victims? With respect to individuals there can be little universal advice. Situations differ, from those where protest could even be life-threatening, to arenas where probably anyone would recognize and protest a micro-inequity. Chester Pierce has called for teaching each person "to be an expert in the analysis of [discriminatory] propoganda."[19] Sartre wrote, "ceasing to be passive takes away all power [from the oppressor]."[20] Margaret Campbell called for, and exemplified, a growth away from denial, toward recognition and analysis of micro-inequities.

I agree with these strategies, as minorities and women grow strong, to see reality as it is, seek and create support wherever possible; to hold up one's head. It often helps to write up micro-aggressions, so that in the aggregate they will help one communicate one's feelings. Many victims have noticed that abuses drop off sharply where people themselves have found it possible to take responsibility for changing their environments. The experience of helping to create a healthier environment for everyone also itself undoes some of the damage done to self-esteem.

Women and minorities vary so much in person and circumstance; it is difficult to find general rules for change. But two rules of thumb are perhaps in order. One person is hardly ever a critical mass; one must seek advice and support. And secondly, it is rarely effective just to complain to oneself; one must responsibly act for change. In doing so, we may help, as well, to foster equal opportunity and more humane environment for everyone.

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FOOTNOTES

[1] With diffidence, because I do not know first-hand what it means to be a minority American, I will discuss the question of micro-inequities very specifically in the context of minority women as well as in reference to all minorities and all women. Some 15% of all American women are minority women and half of all minority folk are female. This group naturally therefore has been part of my concern at M.I.T. and as a labor economist. Minority women, though they made great gains from 1940-1970, are demonstrably worse off in the economy than white women or black men. Like many people I believe this is due to both racism and sexism; minority women therefore deserve more than proportional attention with respect to the subject at hand.

[2] Pierce, Chester, "Psychiatric Problems of the Black Minority." In Caplan, Gerald (ed.), American Handbook of Psychiatry, Vol II. Basic Books, 1974.

See also his "Offensive Mechanisms." In Barbour, Floyd (ed.), The Black 70's. Sargent (April, 1970), pp. 265-282.

[3] Sartre, Jean-Paul, Anti-Semite and Jew. Schocken Books, 1965.

[4] Maccoby, Eleanor and Carol Jacklin, The Psychology of Sex Differences. Stanford University Press, 1974.

[5] Harrison, James, "A Critical Evaluation of Research on Masculinity/Femininity." Unpublished Ph.D. thesis, New York University, 1975.

[6] Money, John and Anke Ehrhardt, Man and Woman, Boy and Girl. Johns Hopkins University Press, 1972.

[7] Green, Richard, Sexual Identity Conflict in Children and Adults. Penguin Books, Inc., 1975.

[8] Treiman, D.J. and Kermit Terrel, "Sex and the Process of Status Attainment." Center for Policy Research, Working Paper, August 1973.

[9] Ellison, Ralph, The Invisible Man. The New American Library, Inc., 1952.

[10] Kent, Martha, "Higher Education and Gender Role Socialization." University of Vermont, 1974.

[11] Campbell, Margaret, "Why Would a Girl Go Into Medicine?" New York: Ann O'Shea, 1973.

[12] Fields, Rona, "The Taxonomy of Sexism." Distributed by KNOW, 1971.

[13] Potter, Stephen, Gamesmanship. Holt, Rinehart and Winston, 1948. See also his Lifemanship, 1951, and One-Upmanship, 1971.

[14] Sartre, J.P., op. cit., p. 17.

[15] Ibid, p. 40.

[16] Pierce, Charles and Gale Allen, "Childism." Psychiatric Annals, 5, 7, July 1975, pp. 15-25.

[17] Brownmiller, Susan, Against Our Will, Men, Women, and Rape. Simon and Schuster, 1975.

[18] Earlier versions of this paper have explored racist and inverse sexist incidents reported respectively by minority people, and by men working in non-traditional jobs like nursing and child care.

[19] Pierce, Chester, "Psychiatric Problems of the Black Minority." op. cit., p. 516.

[20] Sartre, op. cit., p. 137.

SOME THOUGHTS ON COUNSELLING WOMEN WHO PERCEIVE THEMSELVES TO BE VICTIMS OF NONACTIONABLE SEX DISCRIMINATION: A SURVIVAL GUIDE

Eileen Shapiro

SOME THOUGHTS ON COUNSELLING WOMEN WHO PERCEIVE THEMSELVES TO BE VICTIMS OF NONACTIONABLE SEX DISCRIMINATION: A SURVIVAL GUIDE

Eileen Shapiro

This paper describes the types of nonactionable sex discrimination faced by professional women in training and in the work world, with an emphasis on some of the counselling issues that follow from each type of discrimination. The theoretical framework for understanding nonactionable sex discrimination is drawn largely from Mary Rowe's work on this subject, which she has entitled "The Saturn's Rings Phenomenon."[1] While this paper focuses on professional women, and primarily on women in medicine, the description and analysis is applicable to a far wider range of women in educational institutions and in the work place. One key issue not discussed here is perceived discrimination which in fact did not occur, and which the "victim" uses to justify a setback or lack of success.

Nonactionable discrimination--that is to say incidents that have a discriminatory and negative effect on their victims but which are not legally actionable because, taken singly, they are too small or too ephemeral--have been described by Mary Rowe as "micro-inequities"[2] and by Chester Pierce as "micro-aggressions."[3] While such discrimination is often neither intentional nor even conscious, it nonetheless can create an environment that can have pernicious and insidious effects on its victims. Rowe describes the effect of these "minutiae of sexism" by likening them to Saturn's rings: "These minutiae are usually not (practically speaking) actionable, most are such petty incidents that they may not even be identified, much less protested. They are however important, like the dust and ice in Saturn's rings, because, taken together, they constitute formidable barriers."[4]

The ephemeral nature of many of these incidents can leave their victims feeling angry or frustrated or inadequate without knowing quite why; often the victim is unsure whether a real injustice toward her has actually been committed. As a consequence, such incidents can be extremely difficult to "properly" respond to and redress.

In my experience in counselling women who perceive themselves to be victims of nonactionable sex discrimination, most complaints have fallen into one or several of the following categories; condescension, hostility, "backlashing," role stereotyping, sexual innuendo, sexual propositions and assaults, invisibility, and spotlighting. In the following section, each of these categories of discrimination is described and discussed using a minimum of actual examples; a catalogue of examples can be found in items 2-7 in the bibliography.

Categories of Discrimination:

1. Condescension

The experience of being condescended to is essentially the experience of not being taken seriously. While incidents of discrimination involving condescension can be overt and obvious, more often they are atmospheric in nature. In their subtle form--bemused smiles, being called "dear" or "honey," having one's comments not given weight or attended to--such incidents may carry a subliminal message to their victims, a message of implied unworthiness. Most incidents of condescension appear to be unconscious acts; they derive, in my view from a deepseated belief on the part of the aggressors of the victims inferiority as a class, by virtue of their sex.* The overall effect of such incidents can seriously damage or retard the victims' sense of self-esteem and professional identity. For those who do survive such condescension, the price is often feeling as if one must work twice as hard as one's male peers to be successful--and coping with the resultant double pressures to prove oneself and to work even harder.

Redress of incidents of condescension is especially difficult since the most common response to a complaint of alleged condescension is more condescension: the complaint itself is likely to be characterized as not worthy of consideration of, as "trivial" at best, or even as proof that women "can't take it" in the male workaday world. Coping well with condescension requires developing a strong sense of self-worth that includes the right to be a woman professional practicing in a certain field. From the standpoint of that self-confidence and internally derived strength, redress may be possible in the form of raising the consciousness of the aggressor.

The counselling issues are more complex in those cases in which the victims are "buying into" the discrimination. Women who are ambivalent about succeeding and compensate by acting silly, dumb or frivilous may invite a condescending response which may then infuriate them; likewise, women who handle their dependency needs by acting helpless in professional situations may also invite condescension. Perhaps more tragically, for those women who truly believe that their thoughts and work are not worthy of respect and attention, condescending responses are part of a self-fulfilling prophecy. Clearly for these three types of women, recognizing their own role in encouraging a condescending response is of prime importance.

It is also worth pointing out, as a final note, that in some situations, condescension can be used to a victim's advantage; more than one women has pursued successful endeavors unopposed by those in power because her abilities have been grossly underestimated and her efforts not taken seriously.

2. Hostility

Unlike condescension, hostile acts against women because they are women are usually conscious, often in the guise of "humor" (and rationalized as "jokes") and involve some degree of acting out on the part of the aggressor. Mary C. Howell (pseudonym: Margaret A. Campbell) delineates the baiting and belittling forms of hostility as well as outright hostility;[5] to these I would add the fourth subcategory of jokes directed against females as a group.

These four subcategories are fairly self-explanatory. Hostility in the form of jokes directed against women--as, for example, when a professor tells a class of medical students that "the only significant difference between a woman and a cow is that a cow has more spigots"[6]--is usually an attempt to put negative, discriminatory feelings in a socially acceptable form. The aggressor is protected because, after all, it was "only" a joke, as though humor reflected nothing of relevance. Baiting, on the other hand, while also often in the guise of humor, has a very serious purpose: to make the woman angry or to fluster her, particularly in a situation in which performance is measured. When women medical students are told, either by their male peers or their professors, to "go home and bake cookies where you belong"[7] or "because of you a man probably went into chiropractic school,"[8] the intent is hostile, whether the sentiment is clothed in humor as in the first example or stated in a straightforward manner as in the second.

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*For the purposes of this paper, the terms "aggressor" and "victim" will be used to describe the participants in an incident of sex discrimination. Aggressors can be men or women; within the context of the discussions contained in this paper, victims can only be women.

81

The belittling form of hostility is belittling of women in general, of women professionals in particular, and of characteristics traditionally associated with women. Of all the forms of hostility, belittlement is probably the most pernicious in its potential effects on one's professional identity. The belittling of the concerns of women medical students, for example, for respect toward patients, the expression of emotions, and in general for the caring side of medicine, as female and therefore, by definition as unimportant, is destructive both to the women students and to medicine in general.

The final subcategory of outright hostility needs little explanation. Because this form of hostility is not disguised by humor or complicated by any intent other than the expression of hostility, it may be the easiest of the four types to identify as discriminatory. However, all forms of hostile micro-aggressions are intrinsically difficult to cope with. Any appropriate emotional response--tears, anger, frustration--leads to a catch-22: the victim proves she is emotional ("just like a woman"), that she can't "take it like a man," and thus that she is worthy of hostility. A woman medical student at the University of Vermont describes "fearing to express an emotional thought or to defend a point forcefully because I was told: 'Don't be so excitable.'"[9]

But the catch-22 does not end there. Measured, rational responses to acts of hostility can lead to accusations of a lack of sense of humor, or to taking oneself too seriously, or to blowing up a "trivial" event. Silence, likewise, is often not a satisfactory response, since the appropriate anger or/and frustration may still remain.

Basically, there are two kinds of responses that can be effective in dealing with hostile, discriminatory acts. One is the snappy comeback, which is face-saving and humorous while dissipating legitimate anger. But responding with snappy comebacks means surviving by one's wits, in a literal sense, and requires a significant amount of energy. The second way--a serious, calm and quiet response of the sort that says, bigotry in any form is not funny--works occasionally.

One of the great psychological dangers for victims of the hostile form of nonactionable sex discrimination is the tendency to respond hostilely, not only to the aggressor himself, but to others in the same class as the aggressor (e.g. other male professors, or other male administrators, etc.). This reactive hostility ultimately harms the woman more than the group of men (or women) against whom she is reacting, and is an issue counsellors must be attentive to.

3. "Backlashing"

Howell uses the term "backlashing" to describe those micro-aggressions that are a conscious, explicit reaction to feminism, or what Dr. Howell characterizes as the aggressor's "reaction to a sense of threat."[10] Although this category is closely akin to the forms of hostility described in the previous section, I have set it apart because it is not a response to women in general, but only to women identified with the women's movement (usually known as "libbers" in the backlasher's vocabulary), with the implication that other women are okay and the victim should be more like them. Such incidents obviously exert a real, and strong, pressure on women to "stay in line" in order to be seen as acceptable or desirable. It may well be that this influence is stronger, and more pernicious, when exercised by peers than by superiors. In this respect, backlashing is significantly different than the other forms of nonactionable discrimination described in this paper.

To effectively redress incidents of backlashing, the victim must be able to respond without feeding the threat and reaping even worse repercussions, while maintaining self-esteem and not denying personal convictions--a difficult task at best. Backlashing sometimes elicits counterbacklashing which can be consciousness-raising in small doses, but poses the danger of trapping the woman in espousing views in anger or frustration that she does not in truth support.

4. Role Stereotyping

Incidents of discrimination involving role stereotyping are usually fairly unconscious in that the stereotypes manifested are deeply ingrained in the aggressor as "correct" or "natural." There are three types of role stereotyping that are of interest here: being responded to according to the standards of traditional femininity rather than those of the profession in question; being responded to either as being feminine or as not keeping in one's place; and being responded to according to preconceived notions of a woman's role, rather than as an individual.

The first type--being responded to according to the standards of femininity rather than those of the relevant profession--results in comments and actions that are often totally inappropriate to the situation. Thus, a female medical student awaiting an evaluation of her clinical work in a hospital may be told by a doctor in a teaching capacity "that her looks would improve if she wore cosmetics"[11] or to "stand up straight. When you stand up straight, you're a lovely woman."[12] Such stereotyping can obviously result in many professionally relevant aspects of a woman's work being overlooked or ignored, with the consequence that she receives unequal teaching, or a lack of professionally valuable feedback, or unequal consideration for promotion in a work situation.

The second type of role stereotyping--being responded to as feminine (or "good") or as not keeping one's place (or "bad")--is rather straightforward. Being feminine is acceptable and is rewarded; not being feminine --in other words, not keeping one's place--is to be characterized, as Howell points out, as "exhibiting inappropriate behavior" or as being "abrasive," "overly aggressive," "bitchy," or, worst of all, "castrating."[13] Closely related to backlashing, this form of stereotyping exerts strong but subtle pressure on women professionals to act in traditionally acceptable ways.

The final form of role stereotyping considered here--being responded to according to preconceived notions of a woman's role, rather than as an individual--has several variants: being considered as in a particular role (e.g. wife, mother, lover) or as not in a particular role (e.g. not surgeons). To be considered in the role of wife, mother or lover to the exclusion of other simultaneously held and non-sex-related roles can lead to absurd results, as when a woman psychiatrist is introduced to a first year medical school class as "'the wife of one of the city's best radiologists'" or internship interviews that dwell exclusively on how the woman physician's husband feels about her work, when they plan to have children, what kind of birth control they use, and what kind of childcare arrangements they plan to make.[15] In comparison, considering women as *not* in certain roles, for example as doctors-but-not-surgeons (a view I suspect is more common among male surgeons than among their male colleagues in other medical specialties) clearly acts to exclude women from roles they may wish to consider.

In general, of the eight forms of nonactionable discrimination described in this paper, role stereotyping is probably the most amenable to rational discourse, and therefore one of the least difficult forms of discrimination to redress, although not to eradicate. However, one must recognize the ambivalence many women may bring to the kinds of incidents described here. Optimally, these women need to develop a style that is comfortable and appropriate for themselves regardless of whether it is "feminine" in the traditional sense; to accept their multiple roles as occurring simultaneously and not one to the exclusion of others; and finally to see the range of options and roles available to them, despite the real barriers that may exist.

5. Sexual Innuendo

Sexual innuendo as a category of nonactionable sex discrimination can be considered as a subset of stereotyping, but situations involving sexual innuendo are much more emotionally loaded for both the victim and the aggressor. In these situations, the woman is responded to primarily in sexual terms; however, unlike incidents involving sexual propositions and assualts, the sexual intent may be more related to the fantasy dimension than to the real one. In most cases, sexual innuendos represent the aggressor's conscious solution to feelings of sexual discomfort.

Comments containing sexual innuendos are usually made at inappropriate times, often in the guise of humor. They may be phrased in terms of the sexual desirability of the woman, as in the following example reported by a male student at Harvard Medical School, who described that the first time the only woman in his four member tutorial group was absent, the tutor "peered into an examining room and then said to us three male students, 'there's a seductive looking girl in there (the patient). Maybe I should send you in one at a time.'"[15] Or, such comments may be phrased in terms of sexual *undesirability*, as in the following example, also from Harvard Medical School, in which an orthopedic surgeon, who is demonstrating on a female student a tendon test that involves palpating the calf, says to the class: "you squeeze the thigh...you squeeze the thigh...I keep saying 'thigh' because your calves are so fat, they look like thighs."[17] In either case, the woman is treated as a sexual object rather than as in an appropriate work-related role such as colleague, student, patient or employee. As a consequence, especially in learning situations or work situations, women sometimes find that their male colleagues, supervisors or professors are able to treat them *only* as sex objects *or* as neuter professionals. Such a dichotomy can lead to, or exacerbate, uncomfortable conflicts within the women so treated. It is equally clear that many women send out messages that some men may interpret as an invitation to sexual innuendo: the line between acceptable flirting and unacceptable sexualization can be a fine one to tread. Counsellors working with a woman who perceives herself to be the victim of this kind of discrimination must help their client face any conflicts she may have between her sexual roles and her professional roles, and to acknowledge any part she may have played in eliciting the behavior she found discriminatory.

However, even for those incidents in which the woman did not "invite" the sexual innuendo, redress can be extremely difficult to achieve. Merely bringing up such issues often leads to more comments about the victim's sexuality, sexual hangups, or lack of humor. The only incidents of non-actionable discrimination more difficult to redress are those involving sexual propositions and assaults.

6. Sexual Propositions and Assaults

This form of discrimination requires little description. Such propositions and assaults are consciously made, and almost always take place with no witnesses. Further, in almost all cases, the aggressor is a powerful male (e.g. professor or boss) with a relatively vulnerable female (e.g. student or employee). As a consequence, the woman may be at great risk if she refuses the proposition or resists the assault. It is precisely this risk, with its implied threat, that makes these incidents so serious in discriminatory effect.

The counselling issues involved in such incidents are best summarized in the "array of confusing thoughts" expressed by one woman after just such an experience:

> Firstly, what was it that I did that led him to believe I was interested in him in anything but a professional sense? I am quite outgoing and talkative; could that be interpreted wrongly? Second, I realized how utterly vulnerable I was in a situation like this. He is an immensely powerful person with many contacts and if I insult him, he can harm me and my career in a hundred different ways. I don't have any way to protect myself. Everything that happened would be interpreted in his favor, if it ever came public. It would be said that I got my signals wrong, that he was just truly interested in helping me in my career, etc. Third, I realized that should he try to hurt my professional advancement as a result of this kind of situation, there would be no person or formal mechanism to carry my grievances, no person I could complain to that would have any real power to help me. I was left feeling frustrated and defenseless--and very disappointed in the behavior of the person concerned.[18]

7. Invisibility

Invisibility is one of the most prevalent forms of sex discrimination. It is usually completely unconscious but, by its nature, once the aggressor is made aware of having committed invisibility, so to speak, against a woman, his consciousness is likely to be raised to a significant degree. In that respect, invisibility may be the eeriest type of discrimination to experience and the easiest to rectify.

What is invisibility? The following anecdote illustrates the problem:

> A noted woman economist was the only female member of a Ford Foundation seminar. She participated actively in the discussion, as it was in her area of expertise. At the end of the conference, the chairman, a distinguished national government figure, concluded by summarizing the positions and contributions of all the participants except for the woman, attributing all of her remarks, including some very specific suggestions and criticisms, to another man. She was very disturbed at being tacitly ignored in this way, but wondered if she had misperceived the situation and was overreacting. Finally she wrote to the chairman describing what she felt he had done. In his reply, he wrote that at first he had totally disbelieved that he could have done any such thing, but after going over a transcript of the meeting, he realized that she was completely correct. He apologized profusely, and hopefully was more aware of his possible biases thereafter.[19]

Invisibility can be experienced individually, as in the above example; or collectively, as when the assumption is made that all the students or employees are men, and thus employees are instructed to "wear coats and ties" or students receive a letter suggesting that the "wives of students might be interested in daycare facilities;" or institutionally, as when the physical facilities are not adequate for women. This lattermost type is legally actionable and presents a particularly acute problem for women in medicine, who find that the hospitals in which they train and work do not have adequate on-call facilities, bathrooms or changing rooms, or whites and surgical gloves are not available in appropriate sizes.

Invisibility has strong repercussions for women. For students, being invisible either collectively or individually means unequal educations; for professional staff, it means unequal employment conditions. Students cannot be taught, much less evaluated and recommended, by faculty who do not "see" them; employees will not be promoted, or receive accurate evaluations or equitable salaries for work done, by supervisors who are less aware of them than they should be.

While invisible foes occur to women who are articulate and assertive, as in the example about the woman participating in the Ford Foundation seminar, it is true that women who are quiet, unassertive and passive are more likely to be "made" invisible than their more aggressive sisters. But because invisibility, as a discriminatory act, seldom stems from maliciousness, consciousness-raising can occur.

8. Spotlighting

Spotlighting, as defined by Howell, is the obverse of invisibility. It is a relatively seldomly occurring form of discrimination, but is worth noting as a category.

Responses to Incidents of Nonactionable Sex Discrimination:

Howell has suggested a hierarchy of responses to incidents of sex discrimination, starting at the point of "protective denial," with "alert anger" as an intermediate point, and "constructive support" as the desired end point.[20] It can be argued, however, that the responses to such incidents do not fit a neat hierarchy, although some types of responses are clearly healthier than others.

For the purposes of this paper, I would like to identify and briefly describe four types of reactions: denial, depression (and/or frustration), anger, and support groups. Each of these reactions take time and energy; and there are many situations in which the victim is in a no-win situation with no appropriate means of redress with the aggressor.

There are six forms of denial in reaction to sex discrimination. In the first form, the victim does not recognize the incidents to be discriminatory. In the second form, the victim does not acknowledge the discriminatory incidents to have occurred. Denial of this type is common to women who cannot afford the time or the energy to cope with multitudinous incidents of discrimination; for example, those who are the only women or one of a small number of women in a large goup of men--such as women in medical schools twenty years ago, or high level women administrators in corporations or universities today. These women often literally cease to see some of the discrimination that may surround them.

A third form of denial involves recognizing this discrimination but claiming that it is natural and trying to compensate for it, usually by either working twice as hard or acting extra feminine. In the fourth form, the victim recognizes the discrimination and agrees with it, leading to some degree of self-hatred. In the fifth form, the woman recognizes the sex discrmination occurring around her and agrees with it except in reference to herself. This is the classic "Queen Bee" or "exceptional woman" syndrome. And finally, there is the sixth form, in which the victim recognizes the discrimination directed against her, but feels that it has no adverse effect on her: "it just rolls off my back like rain off a duck."

Depression as a response to discrimination needs little description. Given the higher incidence of depression among women as compared to men, however, it is important to consider the disproportionate effect such incidents of nonactionable sex discrimination may have on their victims. Rowe postulates that women are "socialized to respond disproportionately swiftly to disapproval...from white males," but that conversely white males often have been "explicitly socialized to expect hard knocks, to compete ferociously and openly even when injured, and to have a very high pain threshold in the first place."[21] Rowe goes on to give the following illustration of her point:

> If a white male supervisor shouts angrily for five minutes at a young woman, she may not wholly "recover" from the attack for weeks or months or years. Later, in a discussion with the supervisor however, one may hear that he's forgotten his "random grouchiness" or thought it was trivial. Thus, behavior that ought to be trivial or survivable for the model white male may be quite destructive to others, in a manner that has nothing directly to do with the work at hand.[22]

The usual form of this swift reaction to disapproval in the mode of discrimination is, for many women, depression. For others, the reaction to the feeling of helplessness in redressing perceived incidents of sex discrimination is likewise depression. In either case, the depressive reaction effectively impedes the development of the victim's sense of personal worth and professional self-esteem.

Anger as a response to discrimination can be healthy or overwhelming; appropriate or inappropriate. For some women, a relatively small incident can provide the spark to ignite a mountain of previously repressed anger from other incidents that at the time of their occurrence had been reacted to with denial or depression. Such anger can prove too overwhelming to both the aggressor and the victim. In a like manner, an angry attitude toward men in general, caused at least in part by the cumulative effect of discriminatory incidents, can cause a hypersensitivity toward any perceived discrimination and can insulate the woman against potentially positive contacts with her male peers and superiors. With these cautions in mind, the positive value of anger, as an active response to discrimination, should be stressed.

Finally, group solutions for coping with incidents of nonactionable discrimination are often extremely valuable. While there is the very real danger of falling into "groupthink" and particularly of not dealing with the participatory nature of some incidents of discrimination, groups allow individual women to understand their own experiences in a larger framework. For many, the realization that "it's not just me" is liberating, and can help them repair the damage that may have been done to their self-esteem. The sharing of experiences and reactions can be a positive influence on individuals' strategies for coping with discrimination, as well as leading to collective strategy for consciousness-raising among aggressors or potential aggressors. With some safeguards, groups, either formal or informal, can be the milieu in which women develop healthy, productive ways of coping with incidents of discrimination and their psychological effects.

In summary, for counsellors and for individual women or groups of women, there are several issues involved in coping well with incidents of nonactionable sex discrimination. First is the necessity of recognizing, acknowledging and understanding what has occurred and to understand it within a larger framework than the isolated incident or individual. Second is the difficult task of looking within oneself to understand whether and how as a victim the woman may have participated in the discriminatory interaction: how she might have "bought into" the discriminatory assumptions underlying the event; or what conflicts within herself the discrminatory interaction speaks to. Finally, there is the need to assess the effects of such discrimination, to repair past damage and develop strategies for coping well with the future incidents that will inevitably occur. If these efforts are combined with effective consciousness-raising of our peers and supervisors, perhaps we can begin to dissolve our earthly Saturn's Rings.

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FOOTNOTES

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[2] Ibid, p. 1.

[3] Cited in Rowe, p. 1.

[4] Ibid, p. 1.

[5] Howell, Mary C. (pseudonym: Margaret A. Campbell), "Why Would Girl Go Into Medicine." Medical Education in the United States: A Guide For Women, published manuscript, 1973, p. 22.

[6] Ibid, p. 41.

[7] Ibid, p. 24.

[8] Ibid, p. 23.

[9] Shaw, Johanna, Untitled, Manuscript, University of Vermont College of Medicine, 1976, p. 2.

[10] Howell, op. cit., p. 28.

[11] Ibid, p. 39.

[12] Student Task Force, Joint Committee on the Status of Women, Obstacles to Equal Education at Harvard Resulting from Sex Discrimination. Report, Harvard Medical School, Harvard School of Dental Medicine, Harvard School of Public Health, 1974, p. 12.

[13] Howell, op. cit., p. 38.

[14] Ibid, p. 39.

[15] See Gerbarg, Patricia and Lynn Li, "Preliminary Report on Sex Discrimination in Internship Interviews." In Report of the Student Task Force of the Joint Committee on the Status of Women. Report, Harvard Medical School, School of Dental Medicine, School of Public Health, 1975.

[16] Obstacles to Equal Education at Harvard Resulting From Sex Discrimination, op. cit., p. 13.

[17] Ibid.

[18] Anonymous, private correspondence.

[19] Broome, Claire V., "Discrimination at Harvard." Speech delivered at Harvard Medical School Class Day 1975.

[20] Howell, *op. cit.*, p. 45.

[21] Rowe, *op. cit.*, p. 22.

[22] *Ibid*, pp. 22-23.

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FOUR CASE STUDIES
OF SEX DISCRIMINATION COMPLAINTS AND INTERVENTIONS

Joanne A. Lewis

FOUR CASE STUDIES OF SEX DISCRIMINATION COMPLAINTS AND INTERVENTIONS

Joanne A. Lewis

At the San Francisco campus, the responsibility for reviewing all allegations of discrimination has been delegated to the Affirmative Action Office by the Chancellor. Our review becomes the basis for a decision by the responsible manager or grievance committee. All complaints of possible discrimination are reviewed against Federal and state laws and University policy. Complaints are considered to be possible discrimination charges if they allege differential treatment based on race, sex, religion, age, national origin, handicap or status as a disabled veteran or Vietnam-era veteran.

We are fortunate that the administrative structure at the San Francisco campus allows the buck to stop. Our office reports directly to the Chancellor. All Deans, Vice Chancellors, and the Director of Hospitals and Clinics also report to the Chancellor. Unlike some other campuses, the departmental chairs are permanent administrative appointments subject to review by Budget Committee on a five year cycle.

During the past nine years, as a member of The Black Caucus, an informal campus group, and as the Affirmative Action Officer for the past five years, I have had an opportunity to observe the barriers that are difficult to overcome programatically. In presenting these cases for discussion, I hope that suggestions will be forthcoming that will provide additional guidelines to those of us with responsibility for assuring that discrimination is not part of the process in recruitment, selection, retention, development, education, use of resources and facilities, and other aspects of campus and community activities. We believe that early intervention may be the most effective means of confronting the kinds of barriers I am attempting to describe in the following cases.

Case One

During a meeting of the Chancellor's Advisory Committee on the Status of Women, a female student entering her third year presented the following examples of sexist behavior in her school:

1. A male faculty member, very senior, who included in his annual lecture a slide of a nude woman as an example that all "swelling" was not caused by disease.

2. A faculty member who consistently dismissed the class by saying "Thank you gentlemen for coming," although there were 8 female students in the class, and who continued to do so even after the female students called his attention to their omission.

3. The clinical members of the faculty who fail to review their clinical work-ups and walk through the clinics stopping at each station except those occupied by women.

4. Male students, supported by faculty behavior, who do not recognize women students as fellow professionals; treated them as sex objects, and place embarrassing pictures and sex objects on laboratory benches of the female students.

Our discussion determined that the female students in this school were:

1. Not aware of the support available to them to stop the overt behavior and prevent harrassment,

2. Not part of an informal or formal network of women,

3. Concerned about their professional future if they objected to the treatment accorded them by the faculty and fellow male students.

Case Two

A female business manager in a large research unit alleged sex discrimination in the denial of her reclassification request.

In reviewing the case, our office:

1. Reviewed the history of requests for reclassification submitted by this business officer.
2. Collected and compared the job descriptions and responsibilities of other business managers in comparable positions.
3. Had an independent review of these job descriptions by analysts outside the campus Personnel Office and Affirmative Action Office.

We found:

1. That the denials of her requests for reclassification were based on fluctuating criteria. When she met the first set of objections, another set was found.

2. That part of the denial was based on future plans for the research unit; not on the current responsibilities.

3. That persons involved in the review process were not convinced of the validity of the information submitted by this business manager because "they had worked in that department as a dishwasher early in their career and couldn't imagine that her responsibilities were what she says they are."

4. that she would be the only woman on campus, located in a research unit within a school carrying this classification.

Case Three

A black female faculty member alleged discrimination due to the disproportionate workload she was required to carry as compared to other faculty members in the department.

In reviewing the case, our office:

1. Tabulated and compared the number of classes for which she was the faculty of record; the committee assignments by number and type of committee.

2. Tabulated the teaching assignments for courses in other departments.

3. Reviewed the number of students assigned for counselling.

We found:

1. All minority faculty members carried a higher number of classes for which they were faculty of record.

2. Committee assignments were more numerous, but not as prestigious.

3. Teaching assignments for courses in other departments was about the same as for other faculty in the department, but not in the shcool.

4. Minority faculty members carried the largest student counselling load on the average. Only one non-minority faculty member had a larger load.

As part of the facilitation, we found that the department head, the project director, and the faculty member had never discussed the problems brought to our office. We also found that counselling and committee assignments were based in large part on the need to have minority faculty for minority students and minority representation on certain committees, such as the admissions committee and the curriculum committee. We also discovered that the department head and the project director were in some disagreement as to what criteria needed to be fulfilled to assure promotion and retention for faculty members. It was the faculty member's concern for fulfilling research criteria that led to the original complaint.

Case Four

A female applicant for an Assistant Professor position in one of the professional schools alleged discrimination in the selection/review process.

In reviewing the case, our office:

1. Compared the criteria as advertised to that being used by the Search Committee in its review process.

2. Compared the relative qualifications of those in the applicant pool with those of the applicant alleging discrimination.

3. Determined the sex, ethnicity, age and veteran status of the applicants being considered.

We found:

1. The Search Committee had revised the priorities in the criteria in order to accommodate a male candidate.

2. No other applicant met the qualifications as completely as this woman.

In the intervention we discovered that the Search Committee had discussed her marriage to a professor during her graduate education. The committee felt this marriage raised doubts as to the originality of her research. We also discovered that a retired serviceman, with no academic experience outside the service, was to be offered the position since he would not require a full FTE.

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"YOU CAN'T USE IT, BUT DON'T LOSE IT"

SEX IN MEDICAL SCHOOL

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Patricia Gerald Bourne

97

"YOU CAN'T USE IT, BUT DON'T LOSE IT"
SEX IN MEDICAL SCHOOL

Patricia Gerald Bourne

The title quotes a woman Air Force cadet who was being interviewed on the evening news the other night. The occasion was the end of the first year of women's enrollment at the Academy. At the Academy, she explained, the men want you to stay feminine, but they get pretty angry if they think you are "using" your femininity to get more than what you deserve on merit --"You can't use it, but don't lose it."

This issue of incurring men's wrath for "taking advantage" of one's femininity, but of incurring other kinds of approbation for failing to maintain one's femininity, is a theme which comes up over and over again in the interview data I have been working with--interviews with male and female health professions students, faculty, and administrators.[2]

Many of the conflicts and contradictions involved here are due to gender stereotypes and gender role expectations.[3] But there seems to be something in addition which has to do not with gender, but with sex. I raise this issue in the context of this conference because it seems to me that it may have a good deal to do with women being able to assert authority and to be granted legitimacy in roles of authority and leadership; sexual ways of relating permeate daily professional work and they do so to an especially high degree in health professional work.

Sexual relationships, as most of us are currently able to construct them, are not just dissimilar to colleaguial, egalitarian relationships, but are actually contradictory to them; they involve flows of come-ons and responses, initiatives and acquiescences traditional in the male-to-female direction of leadership and compliance. When a come-on gets started, the male-to-female direction of initiative/response is particularly deeply automatic and thus overwhelms and subverts other leadership flows (female initiative or an egalitarian/colleaguial flow) that may have been established in work interactions. It seems that men use this fact of the deepseatedness of power flows in sexual come-ons and interactions--and women comply, wittingly or unwittingly--to weaken and reverse the granting of legitimacy of professional authority to women.

One of the themes which comes up most frequently in the URSA/WAP interviews--be they with men or women--is that of female physicians' "femininity." The men talk about medicine being a "masculinizing" situation, about "hen medics," and about women who "devote themselves" to medicine; they generally think that things are changing, that more "attractive" women are entering the profession now. (They think this is true, not because their opinions of women have changed much, but because the structure of work has changed in medicine, so that there are now time-limited and commitment-limited jobs. Thus, married women can work as physicians and "marriageable" women (i.e. attractive) are entering the field. (Bourne and Wikler, 1977). They also think that women sometimes "use" their femininity to get favors they don't deserve; male students often think, for instance, that women have "used" their femininity to get admitted to medical school.

Female students talk in much the same terms. And they talk about all of this a lot--about "role models" and the lack of acceptable ones, about how they feel men see them, about what they feel happening to themselves ("feeling" feminine or not), about how they see their female peers acting and reacting. They, too, think some of their fellow female students "use" their femininity. Where male faculty tend to be amused and condescending about this, and male students self-righteous and indignant, the female students are angry about it when it happens, because it undermines their own efforts to play it straight.[4]*

In this context, "femininity" clearly doesn't mean gender-appropriate demeanor, it means sex--"using one's femininity" means using one's sexuality. And what does that mean? I'm not entirely certain. Does anyone speak of men "using their masculinity" to get through medical school? No, but probably not because men don't have it and use it, but because the context for this remark so rarely exists--i.e. a context in which a woman is "gatekeeper" or evaluator for men and can be swayed in her judgments by one or the other's sexiness.

Even if the context were to shift so that this were a possibility, it is not clear that such a phenomenon would emerge and be labelled. For all of this sexual influence is premised on some odd notions which don't apply symetrically to women and men. One premise is that women can use their femininity on men because if a man is attracted to a woman, he does her a favor (lets her into medical school, gives her an A for B work, allows her to do a surgical procedure, whatever), so that she will be obligated to him, will owe him a "favor" in return. This seems an unlikely way in which femininity "works" in most cases; certainly in the case of admissions, the connection between the favor and the quid pro/quo is too remote, though it may work well in the case of surgical procedures (see Haseltine, 1976:227).

A second premise behind the notion of "using" one's femininity is something to do with fogging a man's judgment. There is a notion that a woman bats her eyelashes or wiggles, and the male in question turns to jello and gives her an A. This assumption comes clearest in the social-definition case of the other-woman phenomenon. Here a woman is spoken of as having lured or stolen a man; it is as though a man, in all other respects suddently loses all of this under the spell of a sexy temptress, melts into a puddle, and is magnetically and mindlessly sucked into doing something which he has no conscious intent to do at all.[5] It is, of course, interesting that women are granted such astonishing powers in a case like this: the attribution of power to them gets them a great deal of social approbation and gets the male off the hook as having had no active role in the whole adventure. Even if a female medical student bats, gushes, and wiggles incessantly, it is just not realistic or reasonable to even suspect that men are going to "let" her through medical school if she doesn't otherwise deserve it.

In whatever way "using femininity" is assumed to work, it does seem that the notion is probably a false one, which attributes to women medical students a lot of power that they don't have and gets them a lot of criticism that they don't deserve. It certainly robs them of a lot of credit they deserve for being smart. The accusation, or the threat of it, also creates a very great deal of emotion work (Arlie Hochschild's term) for them: they know they need to avoid the label of "using one's femininity," but it seems that the label can be acquired by just being reasonably cheerful.

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*Footnotes 4-24 and 26-27 are quotes from the URSA/WAP interview data. Readers may want to read text and quote--footnotes separately.

Women in the interviews often described a sense of having to monitor themselves to prevent normal-for-them behaviors from being interpreted as sexual come-ons.[6] On the other hand, of course, one of the things that worries many of these women most is acquiring the old hen medic, asexual label.

If the analogy were dresses, definitions of women physicians come in two sizes only: 6 and 18. The definitions are in terms of appearance (a surrogate word for sexuality in this case)--a labelling item not employed for male physicians, oddly enough! Size 6 is sweet, sexy, and manipulative; size 18 is not sexy at all.[7] The sense I get from the data is that men need to fit women in their work environment into one category or the other; if they don't fit readily, pressure is exerted on them to move in one direction or the other until they do fit.[8]

This clear division into two camps, this either/or-ness, suggests that a tension is created when women become professionals such that those around them need to resolve the contradiction by defining them as women or as professionals--if women, sexual; if professionals, not.[9] The notion that women might be both sexual and professional seems astonishing[10] and upsetting.[11]

Women who are either quiet and shy and conduct themselves in a "professional" way, or quite energetic women who are visibly involved in their work, tend to be "resolved" into the professional-asexual camp. Women who are particularly attractive (by traditional male standards) are pushed toward the sexy-not-so-professional camp almost regardless of their behavior, as are women who are nice looking, cheerful, friendly, and joke a lot. (None of these categories is particularly crystal clear, of course. And my making of categories should not imply that individuals cannot escape them along with the levels and approbations; many, many women do. The point here is that two broad ranges of types of women are absorbed into two, narrow, polar, social definitions and that those who escape do so because they are able to manage interactions with incredible astuteness and sophistication, and to be perceived as not-too-this and not-too-that on most occasions.)

It is fairly easy for men to "resolve" women into the asexual category --all they have to do is not talk to them much and never come-on to them.[12] Resolving women into the sexy category is more difficult for a very simple reason: interactions in a professional setting cannot be just cut off; women's professional aspect keeps re-asserting itself. Several strategies are employed:

1. You express surprise and disbelief that such an attractive women could be doing this; this lets her know that she is being granted high status on looks at the outset and so has a lot to lose.[13]

2. You express dismay that she will not be able to do the tough work, thus letting her know that you will think her tough if she proves able to do the work.[14]

3. You tell her, and others when she can overhear, that she is only doing well because men are doing special favors for her because of her looks.[15] That makes her think maybe she wouldn't be doing so well if men stopped defining her as sexy; best of all, it makes her feel like there is not much

percentage in becoming a star doctor because nobody will believe her anyway.

4. You call attention to her sex and the sexual aspect of the relationship frequently; this reminds her of what you really think of her and it gives her attention, thus suggesting that that is the only kind of attention she is going to get (stop being sexy and stop being spoken to).[16]

5. You tease her a lot with mean, sexual jokes; same messages as[17] number 4.

6. You try to make it with her.[18] This settles the ambiguity once and for all and puts her clearly back in (sexual) place. Should she refuse, you can always ignore her and be unpleasant to her and thus move her over to the asexual camp.[19]

Now, is there a way of accounting for this strong need for resolution of women professionals into a category of female/sexy or of professional/asexual? In thinking about this, I went back to Joan Emerson's (1970), "Behavior in Private Places" where she writes about the gynecological examination as a case of multiple contradictory realities. The exam is explicitly a medical procedure, implicitly sexual, so interactions must be managed so as to keep the explicit theme in place. She argues that "no theme can be taken for granted because its opposite is always in mind" (p. 91), and that the exam thus remains precarious and cannot be fully routinized.

This may provide a helpful way of looking at things in the case of women professionals. Women entering the medical work setting step not only into a situation of conflicting realities in the sense of contradictory role expectations about what they are like, how they will behave, and what they are good at, but of contradictory realities in categories of personal relationship. Here is a person to whom one is supposed to relate as a colleague, but she is simultaneously a person with whom one is accustomed to forging some version of sexual relationship--even if it is a negative or neutral one.[20] The whole time that one is carrying on a professional, colleaguial, academic conversation, there is the possibility that one's attention will falter and re-focus on a feature of that person that one is accustomed to making a sexual/evaluative response to.[21] To find oneself thinking about the size and shape of a colleague's breasts while conversing with her about the merits of an article in the latest medical journal is unaccustomed and uncomfortable. One just doesn't know quite what to do.

In Emerson's framework, the reality of a woman doctor as professional is always precarious because the contradictory reality of her as a member of a category one relates to sexually is always in mind. Maintaining the stability of the explicit theme requires constant attention and interaction management. If one can break down the duality, can place the woman back in the person-I-relate-to-sexually category or the person-to-whom-I-relate-professionally-and-with-whom-sexual-interaction-is-not-an-issue category, then things are clearer, more predictable and do not take constant "management."

If it is so stressful to manage these dual themes of a simultaneously sexual and professional category of people, then how is it that the nurse-doctor relationship seems such a stable one, that these two can work and come-on in that relationship quite comfortably? There is symmetry; the sexual relationship fits right in with and complements the work relationship.[22] Being sexual for both doctors and nurses enhances their respective work images and vice versa.[23] Their idea of who they are and what role they are in matches well with other people's versions; the ways each needs to behave to do their work in established ways, are ways that fit with, confirm, and enhance their malehood and femalehood.[24]

Most important is the fact that the work and sex themes can coexist in a stable mix because the direction of power flows is the same in each. Thus, I would suggest an embellishment on Emerson's argument: the explicit and implicit themes in the relationship of male and female professionals result in a precarious and unstable definition only partially because the implicit theme is always in mind and is of a disruptive nature; more important is the contradiction between themes in terms of power (as is the case even with Emerson's gynecological examination case). Sexual relationships, as currently often defined, are antithetical to egalitarian, colleaguial relationships, especially in the come-on stage of sexual encounters.

Men in the medical setting do try very hard to place women in the primarily-a-physician (asexual) category or the primarily-a-woman (sexy) category. It would seem, at first glance, that the first category is the one to go for if one cares about being allowed to do interesting and important work in medicine; it, at least, seems to have possibilities for attaining status equal to men because one has been defined as not-a-woman and because one is not experiencing a barrage of sub-rosa sexual cues which try to turn the power tables each day. Alas, the bargain is not a terrific one. Apart from the general unpleasantness of being treated as neuter, of being viewed as someone who is not a possible mate or lover or even date, it turns out that one doesn't even receive a full measure of professional legitimacy, to say nothing of authority and leadership. Why? Because perceived sexuality turns out to be an important ingredient in valuations that are made of people, male and female, and in subsequent ascriptions and grantings of status. Ask any short male. This is even more so for women. As one of those interviewed said with some bitterness:

> But for a woman to be that boring person, to spend all your time, 80 hours a week in a profession, who would want you? I mean, that's really a very practical question. You have no appeal in doing that. I mean we sell ourselves on our bodies and our personalities, not on our careers. (Group women's interview, Mayberry Med) (1)

And she is more or less right. Women's status has indeed rested more or less on their physical attributes. So in being labelled asexual, one is labelled as an unsuccessful person. This _is_ true for men, too, but to a lesser degree and in a different way. A man who is low on the sexuality scale may be viewed as soft and ineffectual and wishy-washy, but is seen as actually quite a nice, sweet person. But a woman who is low on femininity is so because she is too high on masculinity; and masculine ways of being, when exhibited by a woman, bring an exagerrated and very negative reaction--she is tough (not like Humphrey Bogart is tough, but like Clint Eastwood is tough), she is bossy (remember being a "bossy cow" when _you_ were in the third grade), abrasive, a real unpleasant human being.[25]

Now, there is a high premium in most jobs on people who "get along well" with others, who are "pleasant." Though one might think that doctors would care less about this because of their self-image as independent entrepreneurs, the larger part of professional work is done in organizations and in groups of workers, and great weight is placed on charm. (Dentists who really do work mostly alone, rarely mention personality issues.) Thus, when women are defined as asexual or as neuter-masculine (a label one can get just by keeping quiet--see Norma Wikler's "Sexism in the Classroom" (1976) for good examples, such as students evaluating a woman teacher as "cold," "she doesn't smile enough when she lectures") they are not likely to be granted top marks and top jobs because, smart as they may be acknowledged to be, they are not top people. A sexy woman doesn't have authority; a sexless person doesn't either.

Despite the drawbacks of the asexual label, it seems a more promising route to doing the kind of work one wants to do than does the perpetually sexy role.[26] And I would like to suggest that there is little that women could do among themselves to make the penalities attached to the asexual label less stringent.

The interviews are replete with women's statements about how dreadful it is to be thought of as neuter and as masculine, and it is. But it is a male label of women that women seem to have incorporated to an unusually cooperative degree.[27] Women can place a different loading on the label; and women professionals (nurses are very important here, too) can be aware that if a colleague acquires a label of "tough," that it might have been through no action on her part, but simply through her having chosen not to respond in kind to a sexual indication in the course of professional work.

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FOOTNOTES

[1] This paper draws upon many of the themes and ideas from "Dual Roles and Double Binds: Women in Medicine," by Patricia Bourne and Norma Wikler. (University of California Santa Cruz, unpublished: July 1976). I am indebted to Professor Wikler whose insights are inevitably interwoven here.

[2] The data I will be using here are from An Exploratory Study of Women in the Health Professions Schools conducted by Urban and Rural Systems Associates (URSA), San Francisco, under contract to the Women's Action Program (WAP), Office of Special Concerns, DHEW, (Washington, D.C., September 1976), Contract #HEW-OS-74-291. I am grateful to HEW for their support of the study and to URSA for their fine field work and data analysis. I take full responsibility for the conclusions drawn.

All quotations are excerpts from tape recorded interviews with faculty, administrators and students in the URSA/WAP study. Twenty-seven health professions schools (medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy and public health) were visited in the study. Interviews were semi-structured, open-ended.

My own work with these data has been supported by Faculty Research funds granted by the University of California, Santa Cruz.

[3] Role conflict is spoken of as the clash between competing activists, and between competing personality attributes. All of this somehow leaves out sex. Notions about men being dynamic, aggressive, decision-makers, initiators, leaders, and women being receivers, implementors, compliers, gets close to it; part of the bundle of characteristics spelled out by Broverman, et al. (1970), has to do with appropriate and expected ways of expressing and conveying sexuality. There is a fine line between characteristics and sexiness; perhaps a lot of those areas are defined by, and flow from, sexual behaviors.

[4] R_1 But you know, more than aggressive women, the people in my class who irk me are the couple of women who seem to play the helpless female.

R_2 Ooh, that just drives me up the wall.

R_3 That's the thing I cannot stand to be around and there are a couple of people who do that and that bothers me more than anything.

R_1 Yeah, I mean I think that for myself, one reason why it makes me so mad is because I think it's a problem for all women, and in myself, too, something I've really had to fight. And that's why I get incensed. (Group women's interview, Mansfield Med)

[5] In one of my admissions interviews, the interviewer said, "You'll be a distraction to the other male students who will not be able to study." (Group women's interview, Delta Dental)

6 R_1 But I think there are times when you can end up with two images. One is that you're kind of insensitive, asexual and you're a superlady or a dragonlady who's out to beat every man out of his place in medicine. The other one only takes cognizance of the fact that you are a woman, a female and a potential sexual involvement. I sort of find that one even more insulting because it doesn't take any cognizance of the fact that you've been in school for 16 years. And in conversations with men, everything ends up picking up sexual connotations. And sometimes it's funny, but after a while it really gets on your nerves.

R_2 Yes, it's extremes--either one way or the other.

...

R_1 I'm hard put to understand why the two exist as they do. With the second category, if you are perhaps a woman who is the slightest bit attractive or social and friendly or whatever, it's taken. . .

R_3 Yes, as Marge said, it just makes it worse.

R_2 But then you have to establish yourself as someone who is not competing with a man. You are there to get a medical education, I'm not there to outdo the men in the class, or anybody else, for that matter.

R_1 I think anytime you become visible sort of, in any sense, that you're classified, and I think what I was saying was that if you're at all friendly or social or, as I said, attractive, there's a sort of idea that there's no way that there could be anything else going on inside your head.

R_3 It's not like you don't want to be treated like one of the guys, but you don't want to be treated like one of the guys.

R_2 That's the thing, it's a hard category.

R_3 You change for everybody.

R_2 You can't be the same.

R_3 Be this way to this one, act this way to this one, don't say this to this one because then he'll say that to you and. . .

R_1 Wait, let her say it.

R_3 The most miserable time that I've had in about two years, I cried almost every day. People were coming up to me and telling me I was getting a rep--I don't even want to go into it, but I was getting some kind of rep. So I proceeded to change that rep and then they said I was getting another kind of rep, and I changed that rep, and I was just so turned around. I never knew that if you sneeze wrong here that it's recorded somewhere.

R_1 This is a point which I think I would especially like to make. I have never met people with the gall that I have met people here. Really, because somebody will come up and tell you that. . . For instance, I've been told--and this is with no intent to flatter myself--I've been told 'Well, a bunch of us were sitting around talking about you last night. We decided that you were, we would consider you one of the ten most eligible women in the medical school.' I mean, someone has the gall to walk up to me at 8:15 in the morning and tell you that.

R_2 Or someone will say to you, 'Why are you insulted by that?' It's a constant impinging on. You get up in the morning and you put on a dress. Sometimes you like to wear a dress; you know, you get up in the morning and you're not interested in going to school, so one of my ways of dealing with that is to just make myself feel as nice as I can. So you come to school, and you're not putting on a fashion show, but half a dozen people have to make a whole big fuss about why you have a dress on and, you know, your legs are sticking out. It would be nice if someone would just say, 'Well, you look very nice this morning,' or 'How nice it is that you got up in the morning and took some time to put yourself together.' (Group women's interview, Marion Med)

[7]There were 5 out of 80 girls in my class, but I wasn't really friends with any of them because they either assumed one of two positions: they were either hysterical, you know, overly feminine and that kind of stuff to overcome the prejudices; or they were dumpy, studious, not sexually appealing, weren't interesting. (Female resident, pathology)

There were less than 10 percent females in my class. These women had a hard time going through medical school and changed either to become very coy and seductive, manipulative, or very masculine. (Third year male resident, psychiatry)

[8]There is one woman on the faculty here who is the type where you hear people say, 'When I grow up, I would like to be just like her.' Everyone knew she was good from the first day she came to class and presented a patient; from the way she interviewed him and got the information out they knew she was a good teacher and a good doctor and she was a very attractive woman also. It's a criterion I use for men in the class now--I will ask them what they think about her, and if they are attracted to her (she has nice legs, too) then I know that they have their wits about them. (Male student, Morris Med)

[9]The faculty are either hot or cold, they don't treat you in between. They're either sickly-sweet and want to do everything for you as if you're just a helpless little girl and they want to take over for you, or else they don't like women here and you can't do anything right. (Female student, Delta Dental)

[10]I had lunch with a faculty member last week who is on the admissions committee. He was just raving about all the people he has interviewed in the last two weeks. And one of his examples was this woman who had come in. He said, 'She was a knockout. She was beautiful. And I kept looking for something wrong with her and just couldn't find anything wrong with her. It was phenomenal. If only we can get her.' (Female student, Mansfield Med)

11 R_1 Maybe the concept has been that only very masculine females will go into medicine because of some psychological reason, but you're supposed to keep your sex, your femininity to a minimum in order to achieve this neutral sort of ideal. Do you know what I mean?

R_2 You're automatically assumed to be masculine, and if you do anything at all feminine, people comment about it.

R_1 This is our colleagues and staff, not the patients.

R_2 Certainly we're not eligible for dating. (gets big laugh)

R_3 It's not whether or not they see us as being feminine. I think maybe they do, but at the same time you're not their concept, you're not subordinate enough to be going out with such a wonderful male doctor, cause you have to adore and adulate. (Group women's interview, Morris Med)

12 It (medical school) was a very difficult adjustment for me. And I've talked to many other women since that time about it. At the time it was so painful I could hardly talk about it, but since that time I've talked to a lot of women and it was true for them, too, that I was viewed by the men I associated with as something completely different. In college as a pre-med I hadn't had any of that kind of feeling, or very little of it. Suddenly I was viewed as something that was rather sexless. If I did well in any of my courses it was because I was home grubbing all the time, and studying like crazy. It was the way I had to be viewed. My social life was really limited; to my classmates I was something that was not sexed. (First year female resident, pediatrics)

13 When you see a nice looking woman in medical school, you have to wonder how she got there. She seems to be out of place. (Group men's interview, Morris Med)

14 There are people who believe that a soft, feminine attractive 'lady' can't make the hard decisions, take the long hours. (Male faculty, Morris Med)

15 Look at her legs. You can tell *she's* an A student. (Male faculty, Marion Med)

Things like that happen all the time. Like one guy came up to me and said, 'You just got accepted into med school because you're so cute, now come on up and sit in the front row.' And the guys all laughed and the women hissed. It happens all the time. (Group women's interview, Morris Med)

16 It's little comments, like some people think I'm here to get married. And then if I don't date someone who asks me out, I'm egotistical. Being one of eight girls, I don't know, this may sound kind of bad, I have to say that of the girls in my class, there are a few that are married and of the ones that are single, they're not too outgoing and they don't talk with the guys in our class very much, and so I'm the one that they more or less pick on and tease or whatever because I'm the way I am. (Female student, osteopathic medicine)

One surgeon stood in front of me in the ICU, looked me in the eyes and said, 'You'll notice that all the nurses here are pretty. We only hire pretty girls to work in the ICU,' just to try and get a reaction out of me. (Group Women's interview, Melrose Med)

17 R It happened today in class and I didn't say anything, but they knew that they had hurt my feelings.

I What happened.

R Oh, it was just a joke, I didn't even hear the joke, but I knew something was going on back there, and somebody--I don't know who said it--but I heard my name and it was something about--we were talking about heat, how heat is given off or whatever--and the guys were making a joke about being in heat or something, and I heard my name back there. And that was just it. I really got upset. But they do that all the time to all of us. I'm not the only one. I can handle the jokes, but when my equal ability is questioned compared to a man, then I really get irate because I know I'm just as good or better than many of the men in my class. (Group women's interview, osteopathic medicine)

I realize that it must be impossible being a girl here. The guys act pretty immature at times, and you can't blame them really. But no one should be treated like some of these women are. The jokes are cruel, but they are funny. I don't know. I'm just glad I'm not a woman here. (Male student, optometry)

18 In this illustration, we can take the URSA interviewer as surrogate for a medical student:

> There's no question that part of the reason I enjoy talking to you is that you're an attractive woman. When I walk down the hall and I see one of our attractive female students I give her a hug that I would not give to one of the males. I am not sure that I'll ever erase that from my personality or that anyone else will. (The respondent then requested that the tape recorder be turned off and asked the interviewer out to dinner.) (Male dean of admissions, Morris Med)

19 R_1 And if you refuse to play the game, they'll put you pretty low on the totem pole. If you haven't responded to their cute remarks, it's very easy for them to just sort of keep you to the side instead of saying, 'Come on, get in here. Why don't you do this.'

R_2 A lot of the older instructors here will go out of their way to give a woman a change, though.

R. And yet these same men will play the game themselves. They will flirt around with the girls and turn right around and say, you know, she is successful because she gets such and such done because she flirts around. So they encourage it and yet right away they're ready to comdemn a woman for using her sex to get ahead in her profession. (Group women's interview, Veterinary medicine)

20 The only thing I'm aware of is that there are a lot of sexuality problems that get involved in a very subtle sort of way. There is a difference when you're working with a woman on a team basis or as an intern. In your intercommunications, there's a sexual element that would not enter into it if it were a man. (Second year male resident, psychiatry)

21 The funniest thing is to see--like for example, when I first got here I went out with a medical student (not the one I'm married to, a different one), who was my cadaver mate. Over the cadaver he accepted me as a perfectly capable other person to work with, and then when you go out there's a completely different response. And he couldn't adapt to going back to the cadaver and, you know, going back and forth. He said, 'I can't do that.' At least he was honest and knew what was going on. (Group women's interview, Mayberry Med)

22 And there are also nurses and female patients who can't relate to us, because we don't fit into the typical doctor role, and they're used to having some kind of sexual overtones, sexual role, that goes along with their job. (Group women's interview, Melrose Med)

23 I also think that for men being a medical student is instant kind of sex appeal--you're automatically an attractive person, you know, everyone wants to be with them. Whereas with women it's a very different kind of reaction than other women get because they're kind of in awe of you, but they kind of resent you because you're doing something that they might want to do. Or, it's mixed, and men definitely have a mixed reaction where I would say that male medical students get a more uniformly positive reaction. (Group women's interview, Mayberry Med)

24 The thing of a nurse helping a doctor all tinged with romantic overtones, and the doctor being able to order her around, is an option completely not open to women. (Group women's interview, Mansfield Med)

25 Nancy Henley (1977) argues that dominance is conveyed and reinforced by gestures; touching is one of the most important. When women touch, though, it is interpreted as a sexual gesture; women can't be dominant, so such signals must mean something else like sex. An example from this data set is:

> R_1 That's sort of what we were talking about, I think. When you play it coy, you know, start kidding around, you sort of feel...
>
> R_2 Well, sometimes I've noticed that there's been sort of an attitude underneath--I mean, I touch people when I talk to them and that's just sort of part of me, but they...

109

> R_1 It's strange. The traditional roles are that either you're sort of one of the boys, or you're going out with them, and sometimes it's sort of hard to tell exactly what role you're playing that day. And it will switch around quite often. (Group women's interview, Middleton Med)

This misinterpretation may be an expression of disbelief based on incongruence of stereotype and actual behavior, or it may be a way of denying and short circuiting women's assertions of authority. This helps a lot to explain why women in these interviews so often talk about being misinterpreted as coming-on when they are not--many of the gestures involved in going about your business as a physician are defined as dominance gestures. It may be, though, that these dominance-associated gestures are also sometimes interpreted correctly, or come to be interpreted correctly over time as others learn that a particular person is not coming on. In this case, it may be these very same kinds of gestures that earn one a masculine label. The following interview excerpt suggests that this can happen:

> Often I find that if I were a guy, I could smooth something over with a nurse by kind of flattery, and I can't do that, and I think that the women who have trouble are the ones who try to. At least the ones I've seen who come off kind of masculine are the ones who try to do that--flatter them in their work. It's not really a sexual kind of flirting, but the women doctors who come up to the other guys and put their arm around them and say, 'Well, what do you think about that?'--that kind of acting like a man, I think, makes you be treated like one. (Second year female resident, radiology)

26 Though many argue that this role doesn't hurt, works pretty well and seems to get one by with a little extra boost. For instance:

> There is a kind of flirtatious relationship between myself and many of the attending physicians; I enjoy that and don't think it interferes with the work. In some sense, I think that puts me at an advantage. (First year female resident, neurology)

> 27 I generally get along with my patients very well, even those who are originally uptight about having a woman doctor. But I don't really fit the image of a female doctor becuase I'm not grey, and I don't hover around in black, or hide in corners all kind of dumpy and ugly, you know. (laughs) (Female intern, internal medicine)

SOME INTERACTIONAL ISSUES CONCERNING WOMEN'S PLACE IN THE HEALTH PROFESSIONS

Candace West

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SOME INTERACTIONAL ISSUES CONCERNING WOMEN'S PLACE IN THE HEALTH PROFESSIONS

Candace West

In 1970, Martha S. White was among the first researchers to give recognition to the nonstructural problems faced by women in science, distinguishing between psychological and social barriers to their success. The health professions are likely to accentuate these problems, given that training for such occupations generally requires a period of long and intensive apprenticeship. Women health professionals must cope with additional difficulties which are posed by the sexual stratification of the professions themselves. Since a large part of their training--and the training for any profession--consists of informal interaction (e.g. between teachers and students, "masters" and apprentices, or doctors and nurses), then interaction would appear to be an integral factor in their training and professional experience.

This paper reviews recent research in conversational interaction (West and Zimmerman, 1977; Zimmerman and West, 1975) which reports striking similarities between the pattern of interruptions in male-female interchanges and those observed in parent-child transactions. I use the occasion of this comparison to consider the function of interruptions in verbal exchanges, particularly in conversations between parties of unequal status. Since interruptions are a type of transition between speakers, my point of departure is a model of turn-taking in conversation advanced by Harvey Sacks, Emanuel Schegloff and Gail Jefferson (1974) which provides a systematic approach to speaker alternation in naturally occurring conversation.

The Model

Sacks et al. (1974) suggest that speech exchange systems in general are organized to insure that; 1) one party speaks at a time and 2) speaker change recurs. In other words, the ideal form of conversation would contain at least one but not more than one person talking at a time, and people reciprocally taking turns at speaking and listening. We might imagine such a conversation to be structured in much the same fashion as a script for a play, in which "A" speaks while "B" listens, then B speaks while A listens, and so on--with no gap and no overlap between turns.

However, the peculiar thing about conversation--relative to say, a debate or a ceremony--is that the order in which turns are taken, the length of those turns, and what turns are used to say are all free to vary. Whereas in a debate, "who speaks first" and "about what" is fixed in advance, conversationalists have no such format to follow. Therefore, a problem for them is likely to be: how do you know when it's your turn to speak?

Sacks et al. (1974) argue that a turn consists not only of the temporal duration of an utterance, but of the right (and obligation) to speak which is allocated to a particular speaker. Turns are made up of what Sacks et al. (1974) call "unit-types," which are--esentially--possibly complete utterances. Unit-types can consist of words, phrases, clauses or sentences, depending on their context. For example, a "yeah" answer to a yes or no question would be viewed as complete and sufficient unto itself.

Unit-types are described as "projective" in that they provide enough information prior to their completion to allow a hearer to anticipate an upcoming transition place. In other words, the end of the unit-type is the "proper" place for transition between speaker turns.

Sacks et al. (1974) represent the mechanism for speaker transition as an ordered set of rules. It is through the use of these rules that speakers are seen to achieve a normatively constrained--or preferred--order of conversation. In order to simplify things, the first page of the Appendix to this paper shows a flow diagram of the sequence of "decisions" involved. The rule-set is represented by a vertical array of decision points representing these options with the highest priority decision point at the top. For each possible transition place, these rules provide, in order of priority, that: 1) the current speaker may select a next speaker, for example, by using a term of address; and if not choosing to do so, that 2) a next speaker may self-select; and if not, that 3) the current speaker may continue. The exercise of any one of the three options recycles the rule-set back to the first option.

The operation of the rule-set accounts for a number of regularly occurring features of observed conversations, for example, the alternation of speakers in various orders with brief (if any) gaps or overlaps. That is, the model provides for the systematic initiation, continuation, and alternation of turns in everyday conversation. However, those of us engaging in actual conversations know that "there are still a few bugs in the system." That is, we know very well that people are not always done talking when we think they are, and do not always wait for us to finish before starting themselves.

My particular concern here is with the phenomenon of simultaneous speech. Elsewhere (West and Zimmerman, 1977; Zimmerman and West, 1975), I distinguish between two types of simultaneous speech: overlaps and interruptions. I will begin by considering overlaps, which I have defined as follows: an overlap is a stretch of simultaneous speech which is initiated by a "next" speaker just before a current speaker arrives at a possible transition place. More specifically, a next party who starts to speak within a syllable of the end of a unit-type is seen as overlapping the current speaker's utterance by this definition.

The significance of overlap occurring in such a place follows from the fact that speakers apparently "target" the beginnings of their utterances just at completion by a current speaker. When this is done successfully, the next speaker "latches" her utterance to the utterance of the preceding speaker with no time elapsing in between turns. Turning to Example 1 (see Appendix), we see that Bud begins precisely at completion by Earl, with no time elapsing in between. In contrast, Example 2 (see Appendix) shows an instance of overlap. In this instance, which is by no means rare, the next speaker (Jane) starts up just at what would normally be the end of Mary's unit-type. But, Mary turns out to be stretching or drawling her last syllable, so the two utterances coincide. Other places overlaps are likely to occur is where conjunctions or tag questions are added to otherwise complete utterances, as can be seen in Examples 3 and 4 (see Appendix). Here, both Bert's and Meg's "additions" have the consequence of overlap by next speakers.

An interruption, in contrast to an overlap, involves what might be seen as a "deeper" intrusion into the internal structure of a speaker's utterance. Examining Example 5 (see Appendix), we see Mac coming in with "It's just so smoggy" where Ted is not anywhere near completion of a unit-type, and in fact drops before his utterance is complete. This type of simultaneous speech I have termed an interruption: an instance of simultaneous speech which occurs prior to a possible transition place; operationally, more than a syllable away.

So, what I am calling "overlaps" are events occurring in the immediate vicinity (within a syllable of) a possible transition place, and these can be seen as generated by the ordinary workings of the turn-taking system. My logic here is as follows: each speaker, on commencing a turn, is allocated at least one unit-type before transition according to Sacks et al.'s (1974) model. But, speakers are also oriented to starting turns as close as is possible to completion by current speakers, in order to minimize "gaps" in talk. Interruptions, however, do not appear to have a systemic basis in the turn-taking model as such. By this, I mean that they are not products of the procedures that make up the rule-set.

The Model as an Economy

Sacks et al. (1974) allude to the turn-taking system as a kind of economy, and speak of turns as things that may be valued and sought after, or avoided. For the present purposes, it will be useful to think of the turn-taking model as an egalitarian system. I use this description to suggest two things. First, there is nothing in Sacks et al.'s (1974) model which would suggest that patterned asymmetries should occur between particular categories of speakers. In fact, the model is posited to hold for all speakers and for all conversations (cf. Sacks, et al., 1974:700). Second, I use "egalitarian" in regard to speakers' access to speaking opportunities. By this I mean that we are all presumed to possess the skills and abilities necessary to make use of the rules.

Viewing the turn-taking model as an egalitarian system then, we might think of turns as communicative resources, and of overlaps as conflicts which are "built in" to the system itself. But in terms of the model, the deep incursion into the turn-space of another speaker (what I am calling an interruption) constitutes a violation of turn-taking rules, a denial of equal access to turn-space.

The point of all this is that we are now in a position to notice violations of a preferred order of conversational interaction, and to predict where such "deviations" ought to--and ought not to--occur when speakers orient to that order. Finally, since the model is assumed to hold for all conversations and all conversationalists, we would expect that any distribution of deviations would be relatively symmetrical across categories of speakers or settings.

Methods

Exchanges between 20 same-sex and 11 cross-sex pairs were covertly recorded in coffee shops, drug stores, and other public places in a university community. Parties to these interactions were typically "white" middleclass college students under 35 years of age, whose relationship with one another ranged from intimacy to first-time acquaintanceship. This collection consisted of 10 male-male, 10 female-female, and 11 male-female pairs.

Five parent-child interactions were recorded in the waiting room of a physician's office. These included 2 mother-son pairs, 2 mother-daughter pairs, and 1 father-daughter pair. Children in these conversations ranged from 4 to 8 years of age.

From these conversations, all topically coherent segments were selected for transcription on the basis of the following criteria: (a) 2 or more noticeable silences between speaker turns, or (b) 2 or more instances of simultaneous speech, without regard for who overlapped whom. In other words, I selected stretches of topical talk precisely because of the presence of gaps and overlaps they contained.

I might add that in the process of transcribing, all identifying references were disguised, and the tapes were erased after completion and checking to insure the anonymity of the persons involved. The transcripts were then inspected for instances of simultaneous speech, and the instances classified using the definitions of overlap and interruption specified above. The results of 2 independent classifications were compared with a rate of agreement of 94%.

Of course, this collection of conversations did not constitute a probability sample. So, projections from these findings to conversationalists or conversations at large cannot be justified using the usual logic of statistical inference. My purpose was to develop a conceptual scheme for dealing with gender differences in conversation based on the analysis of empirical materials.

Findings

The same-sex transcripts in this collection displayed silences in nearly equal distributions between speakers. And, as represented in Table 1. (see Appendix), while overlaps occurred with greater frequency than interruptions, both types of simultaneity were distributed equally between male-male and female-female pairs. Further, the interruptions which did occur in same-sex transcripts came from three transcripts, in which they were equally divided between parties to talk.

By comparison (see Table 2., Appendix), cross-sex conversations displayed gross asymmetries. Interruptions were far more likely to occur than were overlaps, and both types of simultaneity were much more frequently initiated by males than by females. For example, 46 out of 48, or 96% of the interruptions in cross-sex pairs were done by males to females. Females, on the other hand, showed a greater tendency toward silence, particularly after interruption by males.

In the parent-child exchanges (see Table 3., Appendix) interruptions are again more frequent than overlaps. I might add here that all of the instances of simultaneity initiated by children came from a single transcript in which a child was trying to gain her parent's attention. And, as we see, both types of simultaneity are much more likely to be done by parents to children than the reverse.

So, the striking asymmetry between males and females with regard to the initiation of interruption is reproduced here in transcripts of parent-child conversation. But, in contrast to the broader range of situations in which the adult conversations were recorded, the parent-child segments are drawn from a single setting, and a rather peculiar one at that. One could argue that parent-child interactions in a more relaxed environment would have a markedly different character. But, the question in any event is whether or not interruptions occur when the issue of who is to control the interaction is salient. The exchanges recorded in the physician's office, while insufficient in themselves to establish the point, do suggest that interruptions are employed by the culturally designated dominant party--the parent--to effect control of the exchange.

Discussion

I would like now to consider some of the ways in which interruptions may function to achieve control and display dominance in both parent-child and male-female conversations. Earlier, I suggested that turns might be viewed as communicative resources. This follows from the fact that observance of the rule-set results in the distribution of opportunities to speak among participants, and the allocation of a segment of time to a speaker.

The time slot under control of a speaker is potentially two things. First, it's a time during which a speaker may engage in activities other than speaking--for example, handling some object. Second, it's a time in which the speaker's utterance may itself unfold as a definite action (e.g., a complaint or an insult). The model assigns the current turn-holder the right to that interval at least until a first transition place is reached. But the listenership of those present and party to the interaction is what ratifies that right. Given that many utterances project not only their endings, but their sense as well, then to listen (or to witness some unfolding behavior) is an act in its own right. It accords at least provisional approval or acquiescence to the action heard (or seen) and acknowledges the right of the speaker to be engaged in speaking. What is being said and what is being listened to combine to permit inferences about the character and the relationship of the speaker and hearer.

Let us begin by noting a commonsense observation about physicians' offices: many, if not most, young children are apt to be apprehensive about what might happen to them there. Parents themselves are likely to feel some anxiety in that setting, given that control over a child is necessary to insure cooperation in the medical examination, to suppress protests and other signs of reluctance to participate, and to prevent uninvited handling of the equipment in the examining room. So, one would expect interactions of the sort illustrated in Examples 6 and 7 (see Appendix). In these cases, adult forebearance of the child's protest or failure to undress could be seen as tolerance of--if not acquiesence--to the child's unruly behavior. If the child is simultaneously engaged in taking a turn at talk and some problematic nonverbal behavior, or if what the child is using the turn to do is problematic, then the parent's presumed obligation to correct or control the child may take precedence over the child's already uncertain right to complete a turn.

The parent's intrusion into the child's turn exhibits or displays the adult's control over the situation and the child, both to the parent and child and to any witnesses. The parent's failure to act in problematic situations is similarly communicative of a lack of control, or even of the child's dominance. Insofar as the parent-child relationship is essentially asymmetrical by our cultural standards, then those occurrences which warrant adult intervention may warrant interruption of the child's turn at talk as well.

Women's Place

In the case of the male-female conversational excerpts, the suggested parallel is obvious: men interrupt women in situations where women's verbal or nonverbal behavior is problematic. Turn now to Examples 8 and 9 (see Appendix). Of the total of 55 instances of male-initiated simultaneity, 14 or 25% appeared to directly correct or sanction the female; and on the whole, were more successful than those done by parents in obtaining acquiesence from the objects of their sanctioning.

These findings would appear to have at least three implications on a general level. First, that the use of interruptions by males is in fact a display of dominance and control to the female (and to any witnesses) just as the parent's interruption communicates an aspect of parental control to the child. Second, the use of interruptions is in fact a control device since the incursion, particularly if repeated, disorganizes the local organization of a topic, as we see in Example 10 (see Appendix). Third, and maybe most important, the occurrence of asymmetrical interruption in these male-female exchanges lends to the hypothesis that certain situations may render gender roles salient. That is, just as the physicians' office is a setting likely to promote parental concerns for control of a child, so too may various occasions and the talk within them trigger male displays of dominance and female displays of submission.

The notion that language and speech communicate the cultural significance of gender is reflected by a growing body of literature in the area (cf. Key, 1975; Lakoff, 1975; and Thorne and Henley, 1975). Earlier, researchers (cf. Hadley and Jacob, 1973; Mishler and Waxler, 1968) have used verbal interaction to index power relations in familial exchanges. But the use of features of conversation as measures of power, dominance and the like has produced inconclusive--and sometimes contradictory--findings, in the absence of an explicit model of conversational interaction per se. The work of Sacks, Schegloff and Jefferson (1974) provides a theoretical basis for analyzing the very organization of social interaction. My hope, through the use of this basis, is to contribute to a deeper understanding of what goes on between males and females interactionally to produce dominance and submission as experienced phenomena.

Women's Place in the Health Professions

Much of the research on women health professionals is concerned with explaining their absence of smaller proportions at the highest paid most prestigeous range of the professions (cf. Kaplan, 1970; Weinberg, 1969; Lopate, 1968). Such studies have led to the hypothesis that reforms of the structural context of women's professional training (e.g., part-time training programs for student mothers, special financial aid allocations for women, and more flexible scheduling of internship provision) would induce women's entry into the upper echelons of the health professions (e.g., dentistry rather than dental assisting, or medical practice rather than nursing).

Another body of literature seeks to account for women's presence in particular health professions (and their absence in others); their drop-out rates in training programs; and their practice in less competitive spheres (e.g. public health programs) in terms of the conflict presumed to exist between women's occupational roles and their sex roles. These investigations (e.g., Matthews, 1970; Dykman and Stalnaker, 1958) suggest that the demands of the work place and demands of the domestic spheres may be mutually incompatible for many women in the health professions.

Lorber (1975) advances evidence to suggest that both the explanations above are insufficient in themselves to account for the existing position of women in the health professions. Pediatrics, she observes (Lorber, 1975), is a specialty in which women are overrepresented, relative to other medical fields in which women doctors are present. And yet, pediatrics is noted for its irregular hours, which are difficult to reconcile with women's domestic roles. Implicit in Lorber's (1975) analysis of a "sexual tracking system" (p. 83-84) is the notion that reforms of the structural context of women's experience in the health professions would do little to affect the informal aspects of the professional patronage system. This professional network, consisting of the "inner fraternities" of medicine, is seen by Epstein (1971) to groom, recommend, refer, and assist men into--and women out of--high prestige, high income specialties and types of practice within the health professions.

The purpose of this paper has been to suggest that informal interaction between men and women may play a subtle but significant part in the day-to-day operation of the sexual tracking system Lorber (1975) describes. We have seen the consequences of the use of interruptions by males and by parents for women and children in casual conversation. We can only speculate as to the impact of such phenomena in a sexually stratified professional environment. However, it seems reasonable to entertain the notion that male interactional dominance would be a particularly salient feature of situations in which culturally legitimated authority figures are male (e.g. as doctors *vis a vis* nurses, as dentists *vis a vis* dental assistants, and as "masters" *vis a vis* apprentices). And, in innumerable situations, we can imagine how the social significance of those professional distinctions might be played out (e.g. in prescribing medication, performing rather than assisting in examinations, etc.) in and through verbal interaction.

Now, in any particular conversation, at any particular time, the consequences of such occurrences as interruptions may initially appear to be trivial. After all, as Goffman acknowledges "Whether your job termination interview is conducted with delicacy or abruptness, you have still lost your job" (Goffman: 1976:74). However,

> "Routinely...the question is that of whose opinion is voiced most frequently and most forceably; who makes the minor ongoing decisions ---required for the coordination of any joint activity, and whose passing concerns are given the most weight. However trivial some of these little gains and losses may appear to be, by summing them all up across the social situations in which they occur, one can see that their total effect is enormous.
> The expression of subordination and domination through this swarm of situational means is more than a mere symbol or affirmation of the social hierarchy. These expressions considerably *constitute* the hierarchy; they are the shadow *and* the substance."
> (Goffman, 1976:76)

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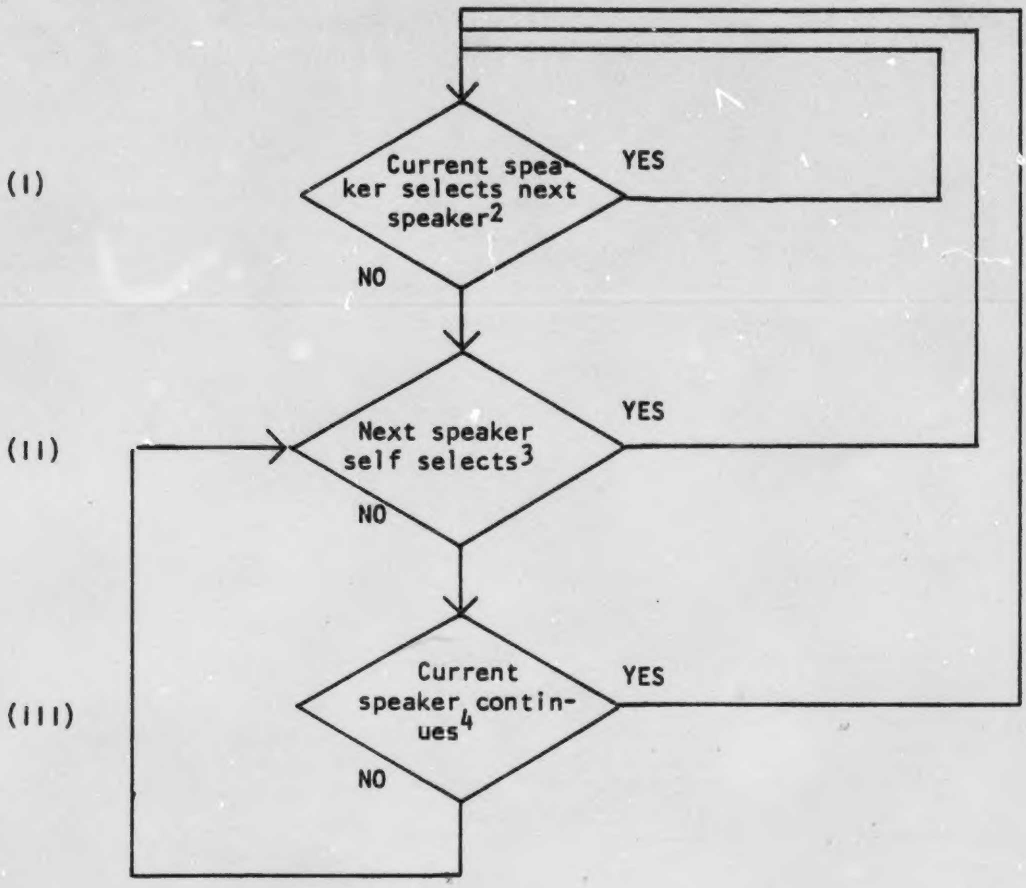
APPENDIX

Flow diagram of the "decision" points in Sacks' *et al.* (1974) model of turn-taking in naturally occurring conversation[1]


(I)
Current speaker selects next speaker2
YES
NO
(II)
Next speaker self selects3
YES
NO
(III)
Current speaker continues4
YES
NO

Notes:

1 The "decision" points are for each possible transition relevance place.

2 The person selected by the current speaker has the exclusive right (and obligation) to speak next.

3 Next speaker other than current speaker.

4 Current speaker is not obligated to speak next.

TRANSCRIBING CONVENTIONS

The transcript techniques and symbols were devised by Gail Jefferson in the course of research undertaken with Harvey Sacks. Techniques are revised, symbols added or dropped as they seem useful to the work. There is no guarantee or suggestion that the symbols of transcripts alone would permit the doing of any unspecified research tasks; they are properly used as an adjunct to the tape recorded materials.

(Example n TQ:1-2)	For the examples here, sources of conversations from which they were taken are provided in parentheses. Published sources are designated by author, and those with a "T" indicate the number of the conversation in a laboratory setting. Those examples prefaced by no sources are taken from the data collected in natural settings.
Mary: I don' [know] John: [You] don't	Brackets indicate that the portions of utterances so encased are simultaneous. The left-hand bracket marks the onset of simultaneity, the right-hand bracket indicates its resolution.
A: We:::ll now	Colons indicate that the immediately prior syllable is prolonged.
A: But-	A hyphen represents a cutting off short of the immediately prior syllable.
CAPS or underscoring	Both of these are used to represent heavier emphasis (in speaker's pitch) on words so marked.
A: 'Swat I said= B: =But you didn't	Equal signs are used to indicate that no time elapses between the objects "latched" by the marks. Often used as a transcribing convenience, it can also mean that a next speaker starts at precisely the end of a current speaker's utterance.
(1.3)	Numbers encased in parentheses indicate the seconds and tenths of seconds ensuing between speaker turns. This may also be used to indicate the duration of pauses internal to a speaker's turn.
(#)	Score sign indicates a pause of about a second that it wasn't possible to discriminate precisely.
((softly))	Double parentheses enclose "descriptions," not transcribed utterances.

Example 1. Latched utterances (from Jefferson and Schegloff, 1975:3)

Earl: How's everything look.=
Bud: =Oh looks pretty goo:d,

Example 2. Overlap over last stretched syllable

Mary: Um so where's your shoror-
sorORity house. Is it on
campus or off: [:?]
Jane: [No] it's
off=all thuh sororities and
fraternities are off campus.

Example 3. Overlap over tag question (from Sacks, *et al.*, 1974:703, n. 12)

Bert: Uh you been down here before [havenche]
Fred: [Yeh.]

Example 4. Overlap over conjunction

Meg: I don't like it at all [but-]
Pat: [You d] on't

Example 5. Interruption prior to possible transition point

Ted: It really sur [prised me becuz-]
Mac: [It's jus' so smo:g] gy. . .

Example 6. Interruption over child's utterance

Child: But I don't wanna shot! ((sobs)) you
said (x) said you said [I]
Parent: [Look] just be
quiet and take that sock off or you'll
get more than just a shot!

Table 1.

INTERRUPTIONS AND OVERLAPS IN 20 SAME-SEX TWO-PARTY CONVERSATIONAL SEGMENTS

	FIRST SPEAKER*	SECOND SPEAKER	TOTAL
INTERRUPTIONS	43% (3)	57% (4)	100% (7)
OVERLAPS	55% (12)	45% (10)	100% (22)

*For a given segment, the person speaking first is designated first speaker; the person speaking second is the second speaker. There is no necessary implication that "first speaker" is the one who initiated the conversation, e.g. the first to utter a greeting, etc.

Table 2.

INTERRUPTIONS AND OVERLAPS IN 11 CROSS-SEX TWO-PARTY CONVERSATIONAL SEGMENTS

	MALES	FEMALES	TOTAL
INTERRUPTIONS	96% (46)	4% (2)	100% (48)
OVERLAPS	100% (9)	--	100% (9)

Table 3.

INTERRUPTIONS AND OVERLAPS IN 5 PARENT-CHILD TWO-PARTY CONVERSATIONAL SEGMENTS

	ADULTS	CHILDREN	TOTAL
INTERRUPTIONS	86% (12)	14% (2)	100% (14)
OVERLAPS	66% (2)	33% (1)	100% (3)

Example 7. Interruption over child's utterance

Child: If I get one wi [th a]
Parent: [Leave] that alone Kurt
(1.8)
Child: Huh?
Parent: Don't touch that roller

Example 8. Interruption occurring over female's utterance

Female: I guess I'll do a paper on the economy business
he laid out last week if [I can]
Male: [You're] kidding! That'd be a
terrible topic.

Example 9. Interruption occurring over female's utterance

Female: So uh you really can't bitch when you've got all
those on the same day (4.2) but I uh asked my
physics professor if I couldn't chan [ge that]
Male: [Don't] touch that
(1.2)
Female: What?
Male: I've got everything jus' how I want it in that
notebook (#) you'll screw it up leafin' through
it like that

Example 10: Interruption occurring serially over female's utterances

1 B: How's your paper coming?=
2 A: =Alright I guess (#) I haven't done much in the past two weeks
3 (1.8)
4 B: Yeah::: know how that [can]
5 A: [Hey] ya' got an extra cigarette?
6 (#) ?
7 B: Oh uh sure ((hands over a pack)) Like my [pa]
8 A: [How] 'bout a match?
9 (1.2)
10 B: Ere ya' go like my [pa]
11 A: [Thanks]
12 (1.8)
13 B: Sure (#) I was gonna tell you [my]
14 A: [Hey] I'd really like ta' talk but I gotta
15 run (#) See ya'
16 (3.2)
17 B: Yeah
((END CONVERSATION))

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VI.

CAREER PATTERNS: CHOICE OR CHANNELING?

Despite the informal and formal barriers to women's advancement in the health care professions, some women do manage to achieve positions of leadership and authority.

Wilson and Jones give us background on how women physicians have managed the dual roles of family and professional life in the past and assess some of the requirements for women's future career development. Cartwright investigates personality factors related to continuous and noncontinuous medical career patterns for women. Davidson considers questions of male identification and examines the effect of women's choice of direction, personal style, and field of specialization.

CAREER PATTERNS OF WOMEN IN MEDICINE

Marjorie P. Wilson

and

Amber B. Jones

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CAREER PATTERNS OF WOMEN IN MEDICINE

Marjorie P. Wilson and Amber B. Jones

> "The tasks of social change are tasks for the tough-minded and competent. Those who come to the task with the currently fashionable mixture of passion and incompetence only add to the confusion."
>
> John Gardner

Physicians often assume each of several socially valued roles: healer, counselor, teacher, and informed decision-maker. Women who choose medicine as a career have selected a profession which allows them to affect significantly the quality of life around them.

In addition to meeting the demands of a multi-variety professional role, women physicians expect to assume the more traditional and equally demanding responsibilities of wife and mother. The combination of personal and professional obligations constitutes an awesome set of expectations. A framework from which to orchestrate these interdependent functions is a critical factor in the degree to which women physicians can achieve their fullest potential. We believe this framework must incorporate at least three key variables: 1) a clear vision of personal and professional life goals; 2) a broad knowledge and understanding of the forces, demands, and conditions imposed by the relevant social environment; and 3) access to substantive and political information of significance in the accomplishment of the multiple tasks.

After summarizing some of the retrospective data about career patterns of women in medicine, we will post four key questions.

Many of the statistics we shall present are from the Chart Book prepared for the International Conference on Women in Health Careers, held in Washington, D.C. in July 1975.[2]

1. In 1974, women comprised 39.4 percent of the total labor force in the United States, and 46.4 percent of all women of working age were in the labor force. (Figure 1)

2. In the medical and health services industry, which employs over 4.2 million workers, the employment of women increased from 65 to 75 percent of the work force in the 20 years from 1950 to 1970. (Figure 2)

3. Among the 3.1 million persons in selected health occupations in 1970, the proportion of women ranged from 3.4 percent dentists to 97.0 percent dental assistants. (Figure 3)

4. Thirty-five percent of women compared with 57 percent men were in office-based practice, and 35 percent were in hospital-based practice compared to 25 percent men.

5. The northeast region had a significantly larger proportion of women. (Figure 4)

6. In 1973, Pediatrics (21.9%), Anesthesiology (14.4%), Pathology (14.0%), and Psychiatry (13.7%), had the highest proportions of women within the specialty... although, (Figure 5)

7. The largest numbers of women entered Pediatrics (4,572), Psychiatry (3,436), Internal Medicine (3,234), and General (Family) Practice (2,561).

8. Data indicate that the more popular specialties for women physicians have the lowest net income for both men and women. The conclusion based on a study of 1,400 women and 7,000 men physicians was that the average net income from medical practice in 1972 was $47,945 for men and $27,558 for women physicians, related in part to hours worked.

9. Women represented just under 15% of the total full-time faculty of U.S. medical schools in 1971-1972 and again in 1973-1974. Only a small percentage of women are at the professor or associate professor level on medical school faculties. (Figure 6)

10. Although it is usually assumed that many more women faculty are on a part-time basis as compared to men, the difference is perhaps not that striking. (Figure 7)

11. A greater proportion of the women than of the men graduates for every medical school class since 1940, except those of 1945 and 1946, are now on medical school/center faculties.[3] (Figure 8)

First year enrollment of women medical students reached 24% in 1975-1976.[4] This year, 21 medical schools had at least 30% women students in the entering class. Findings have been relatively consistent in a number of studies in the past decade.[5] The conclusions are as follows. Women physicians do marry in the same proportion as women generally, but marry later in life and tend to have fewer children. Over half are married to physicians.[6] About one-third of the women are on fixed salary/fixed hours appointments, whereas 15% of the men are. Sixty-three percent of women are not board certified, and 49% of men are not. The studies of the late 1960's all showed that almost 91% of women physicians remained active on full or part-time basis. All studies have shown that the number of hours per year worked by women is substantially less than men, but Powers makes the point that this fact can be partially related to the nature of the positions in which they work.[7] William's study of Radcliffe women showed that two-thirds worked more than 35 hours per week and many worked more than 60.[8] A recently published study, by Judith Jussim and Charlotte Muller, calculated the average time spent in practice by women to be 32.6 years and for men, 35.8.[9]

These statistics present no new or original data, but make the following points clear:

.Women predominate in the work force in the health field.

.They are generally paid less than men.

.They hold fewer top level positions.

.The enrollment of women in medicine is now significantly greater than ever.

.A greater proportion of women medical graduates enter academic medicine than men graduates.

.Women do frequently combine career and family life.

I would like to focus on four issues, posed as questions, which I believe involve forces which will modulate the careers of women physicians in the future.

QUESTION 1. Will the proportion of women physicians ever reach the proportion of women in the general population?

An Association of American Medical Colleges administered delphi survey of the Council of Deans of the U.S. medical schools predicted that by 1985, 30% of the physician population would be women.[10] We believe that we will reach that proportion; however, we doubt that women will be represented in medicine to the same extent that they are represented in the general population. As long as the present economic structure exists, the masculine culture of the profession will be slow to change. However the possibility of National Health Insurance would bring far more regulation to medicine and the probability that it would be less attractive to those whom the dollar drives; therefore, the proportion of women in medicine may increase further.

QUESTION 2. Do women physicians want leadership roles? Can women doctors attain a fair share of managerial and executive positions in the future in proportion to their numbers in the work force?

To reflect for a moment on what leadership means, Douglas McGregor in The Human Side of Enterprise says that many characteristics which have been alleged to be essential to the leader turn out not to differentiate the successful leader per se.[11] In fact, some of these--integrity, ambition, judgment, for example, are to be found not merely in the leader, but in any successful member of an organization.

The marks of success, as well as leadership, for women physicians may simply be high standards of professional care, to practice with compassion, and in specialties of their choice. Can women physicians provide some of the answers to the type of criticism of the current approach to practice that Ivan Illich's controversial book, Medical Nemesis raises?[12] The disaffected public reflects some of the same dissatisfaction. Even though the number of women physicians in the total health services work force may always remain relatively small, this small number of women can have an enormous influence on the quality of life in the general population through their standards of practice and their approach to their work.

We believe there is evidence in studies of women Ph.D.'s which challenges Horner's achievement motivation theories based on the concepts that women fear and avoid success. We do not believe that it is fear of success (or failure) that has kept women from executive positions in medicine. There is no denying the fact that senior administrative positions are rarely occupied by women. One possible explanation for this phenomenon is that the older generation of women physicians entered medicine with the principal career goal of independent practice. As a result, effort was focused on the care of individual patients rather than on lobbying for personal status in organizations. In the past two or three years, a number of women have indicated an interest in managerial roles and some have been thrust into positions of major administrative responsibility. The notion of aspiring to these roles has come to them relatively late in their careers; they should have long ago been on a different career track in order to be groomed for positions such as department chairman, dean, vice president, hospital president, or trustee. Job changes have been in the absence of any clearly articulated career goal. As a result, there is generally no pattern of experience among women physicians linked to progressively responsible managerial roles. This uneven career development has provided a justification for denying women positions with real growth potential. A recent American Public Health Association study of professional communication networks in the professional communities suggests that formal and informal channels of communication play a crucial role in the career development process.[13] Professional recognition is crucial to both vertical and horizontal mobility within a field. Women have had differential access to the colleague system, the sponsor-protege relationship, and in the past, committee memberships through appointment or election, particularly in professional associations.

In discussing leadership and the development of managerial talent, McGregor makes the point that growth of the individual depends heavily on the environment in which the individual works. McGregor believes that the individual will grow into what (she) is capable of becoming, provided we create the proper conditions for that growth. He describes a process of self-development leading to the realization of the individual's potentialities. Perhaps another area where we can work, therefore, is to help create the proper conditions for growth for women in the professional environment and to provide assistance with the process of self-development. For example, we have no doubt that physicians in administrative positions need to acquire knowledge of and facility in using managerial tools. This is one area in which we can speak from experience since over the past five years we have sponsored an executive development program for senior medical school administrators. They learn how to run effective meetings, how to work with small and large groups of people, to manage conflict, to set goals and objectives, priorities, and criteria for success. They learn quite a lot about fiscal management and get advice about how to manage their time and the use and misuse of management information systems, computers, forecasting, and modelling. However, few women physicians have had an opportunity to participate in such training sessions as so few occupy senior decision-making positions.

QUESTION 3. How can women physicians cope with the super-women role of career and family?

Professional careers are not a substitute or a partial tradeoff, but an addition to the role of the mother/wife/homemaker. It is surprising to find that "superwomen" does not lament her lot in life, per se. The question is, does it present a hazard for the profession, for the family? How can we assist competent and dedicated women to fulfill effectively the multiple roles they assume? If women expect special consideration in terms of working hours and or conditions, can they expect to be appointed to demanding leadership roles? While it is true that the over-worked male physician is a subject for careful study and serious concern, it is also true that those men who have succeeded in leadership positions have devoted an inordinate amount of time and energy to their work.

Perhaps the most effective way to deal with the superwoman phenomenon is to devise ways to ease those burdens which the woman professional need not bear, so that she can concentrate her energy on those aspects of her work and family life that only she can do. The conflicts between roles are often representative of role overload and time bonds rather an indication of any intrinsic functional incompatibility. For example, more equitable salaries, more favorable tax laws, and models of sharing personal resources among women with like concerns can stretch the ability to purchase needed services and time-saving procedures and devices. A mutually supportive network of women in academic medicine has been suggested as a means to facilitate access to necessary professional information; a more personal support network might be equally important. For example, access to the body of knowledge about setting personal life goals and about time management and other coping strategies could be enormously helpful.

We are all aware that a critical issue for the professional woman is the potential influence of her behavior on her family, particularly her children. In preparing this paper, we thought at length about the responsibilities of a good parent. Our conclusion was that the quality of life issues within the family are not exclusively female or motherhood responsibilities, although women professionals may tend to take them on as if they were exclusively theirs, and not necessarily shared responsibilities, and they may feel guilty accordingly.

QUESTION 4. Do women physicians understand and can they deal with the hostility among large numbers of women health workers toward male physicians and administrators who dominate the health services industry?

This last question is perhaps the most critical one of all. A year ago, the International Conference on Women in Health reflected in no uncertain terms the growing assertiveness among women health workers of all types. It is not all sweetness and light; my call for quality performance among woman physicians is not that we go forth simply as a gaggle of do-gooders. We have a quotation from John Gardner at the beginning of this paper which reads as follows: "The tasks of social change are tasks for the tough-minded and competent. Those who come to the task with the currently fashionable mixture of passion and incompetence only add to the confusion." The International Conference reflected a growing realization among women health care providers that not only must the distribution of women within the medical industry hierarchy be changed, but the hierarchy itself must also be reconstructed. The conference atmosphere was highly charged; the hostility towards physicians, particularly, was arresting. Women health professionals do not want merely to take men's places, act as men do, and to become the dominant rather than the dominated. As women, they were concerned not only with improving the status and representation of women as providers of health care, but with breader goals as well.

In spite of the above-mentioned underlying resentment of physicians, there were recommendations from the Conference to increase the number of women physicians. We believe women physicians could make a tremendous contribution toward improving professional and working relationships between physicians and nurses and among other health professionals. As we pointed out, 75% of the total health services work force is female.

We shall paraphrase a few thoughts from the Conference to indicate the flavor of the meeting:

1. Participants acknowledged that the greatest proportion of health care is provided within families-by mothers and daughters; it was recommended that caregiving skills be taught in a manner that would decrease dependency upon impersonal professional services and increase the competence of mothers and daughters giving the first line care in the home.

2. Participants discussed what it was like to receive health care services from "alien and alienating providers." It was recommended that citizen groups have a determining voice in the selection of health care trainees, including physicians, in order to influence the attitudes of future health professionals.

3. Participants wanted to redirect training programs, and to redirect the manner in which health care services are provided for mothers

> and their children. The view was expressed that pushing highly credentialled token women into showcase jobs sometimes co-opted these women. Therefore, it was recommended that the cause of the conferences be represented in policy determining positions by women "from their ranks, empowered by their constituency."

In the article, "Women in Health Care," author Vincente Navarro believes that the inclusion of women in positions of power in institutions will be a necessary but not sufficient condition to improve the situation of the majority of women in the health sector; he summarizes by saying that the betterment of a few does not imply, nor does it result in (necessarily) the betterment of the many.[14] If women physicians are to be instruments of change in the health care field, they must understand the social, political and economic forces which are involved.

Another group of women working to improve the status and responsibilities of women as providers of health care have formalized a series of objectives for accomplishing their goals. We will mention only three of particular relevance: 1) Increase the percentage of women physicians to a minimum of 25% of all U.S. physicians by 1986, 2) Increase the number of entering female students to at least 45% by 1986, and 3) Increase the number of women in health care decision-making positions in the health care delivery system, in academic institutions, and within the Federal, state and local agencies by increasing the number of women in management positions in the health field (government and private) by at least 20% in 1986.[15]

There are clearly some contradictions and conflicts around the possible answers to the four questions that we have posed. (Our last figure (Figure 9) illustrates this kind of paradox.) Whatever directions women physicians seek in their careers in the future, we believe a great deal of help can be provided to them which can assure their success and relieve their stress. Access to needed information can be provided through networks of women physicians and other professionals. The generation of appropriate literature, workshops and seminars can enhance the quality of their contributions in all aspects of their professional and family lives.

We would suggest that we are moving into a fourth era which we can add to Marion Kilson's three phases of Formation, Consolidation and Reintegration. We do not have a precise descriptor for this next phase of development, but it will be characterized by far greater attention to the human values of our culture. Will women physicians display greater humanity in the treatment of their patients, in their treatment of each other, in their behavior within organizations and in the community?

If women physicians are to have a determining influence, there must be more dialogue among thoughtful and mature women about the future role of women physicians during this era of change. We must be clear about our values and what we stand for, we must have a set of goals and some pragmatic achievable objectives for the next five years. There can and should be an organized effort for developing the leadership talent among women physicians that the medical profession and our country needs.

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FOOTNOTES

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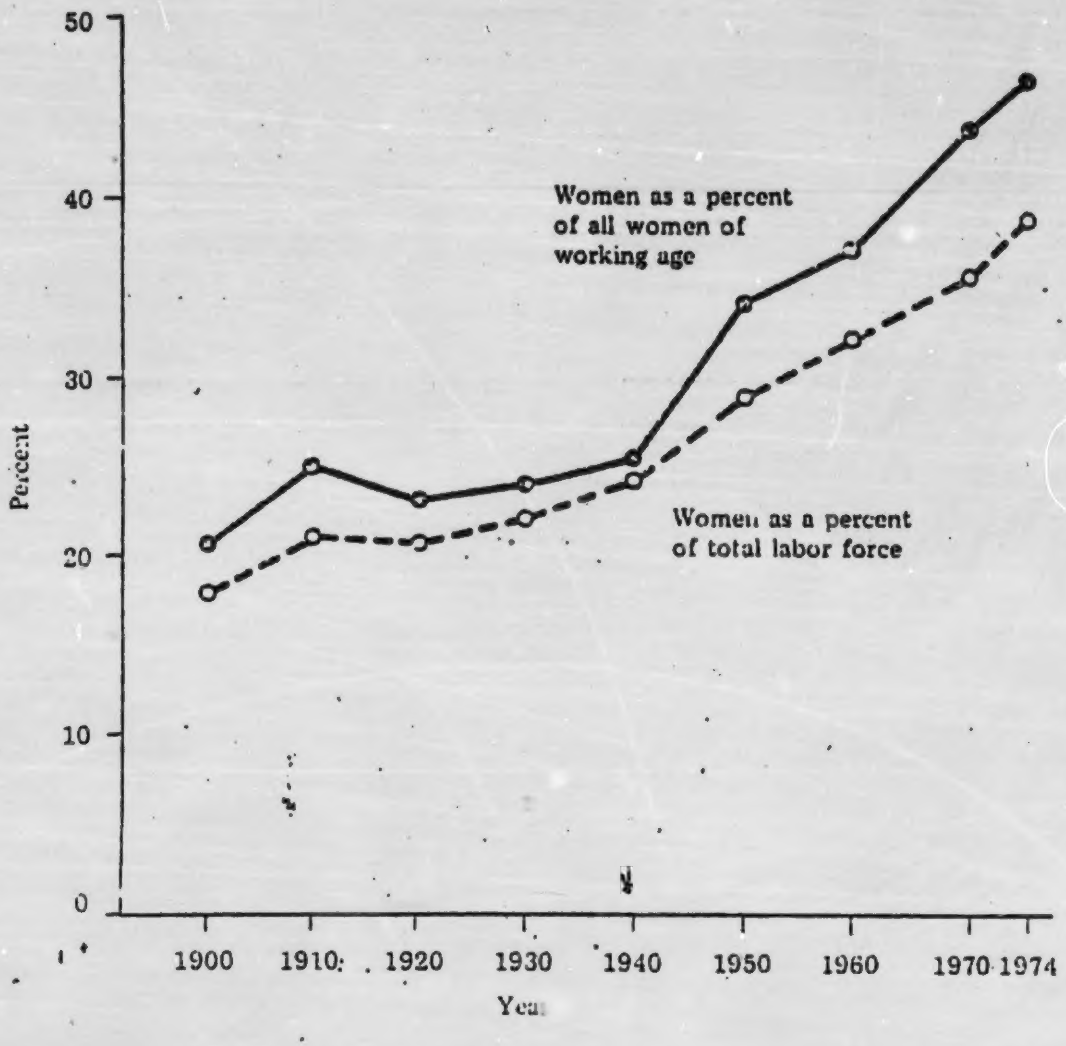
Since 1900, women in the labor force have increased from 18 to 39 percent of all workers . . . from 20 to 46 percent of all women of working age.

Figure 1 WOMEN IN THE CIVILIAN LABOR FORCE: 1900-1974



About 36 million women are in the civilian labor force, either working or seeking work.

Table 1. WOMEN IN THE CIVILIAN LABOR FORCE: 1900–1974

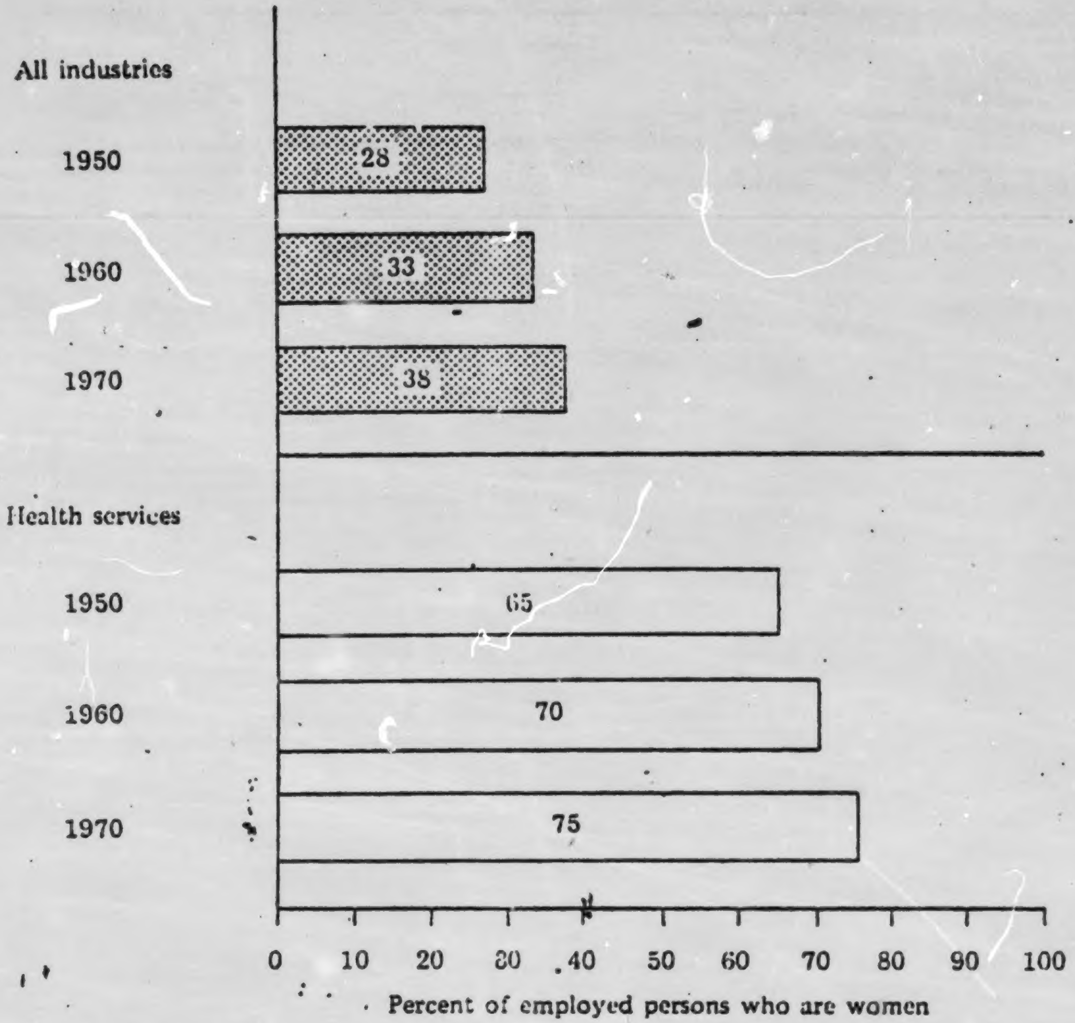
Year	Women in labor force (1,000's)	Women in labor force as percent of	
		Total labor force	All women of working age
1900	5,114	18.1	20.4
1910	7,889	20.9	25.2
1920	8,430	20.4	23.3
1930	10,679	22.0	24.3
1940	12,845	24.3	25.4
1945	19,270	29.6	35.7
1950	18,112	28.8	33.9
1955	20,584	30.2	35.7
1960	23,272	32.3	37.8
1965	26,232	34.0	39.3
1970	31,560	36.7	43.4
1972	33,320	37.4	43.8
1973	34,510	38.9	44.7
1974	35,825	39.4	46.4

Source: Women's Bureau, *The Economic Role of Women*, Reprinted from *Economic Report of the President, 1973*, U.S. Department of Labor, Washington, D.C., 1973, p. 9.

For 1973 and 1974 data—Bureau of Labor Statistics, *Employment and Earnings* Vol. 21, No. 9, U.S. Department of Labor, Washington, D.C., p. 91.

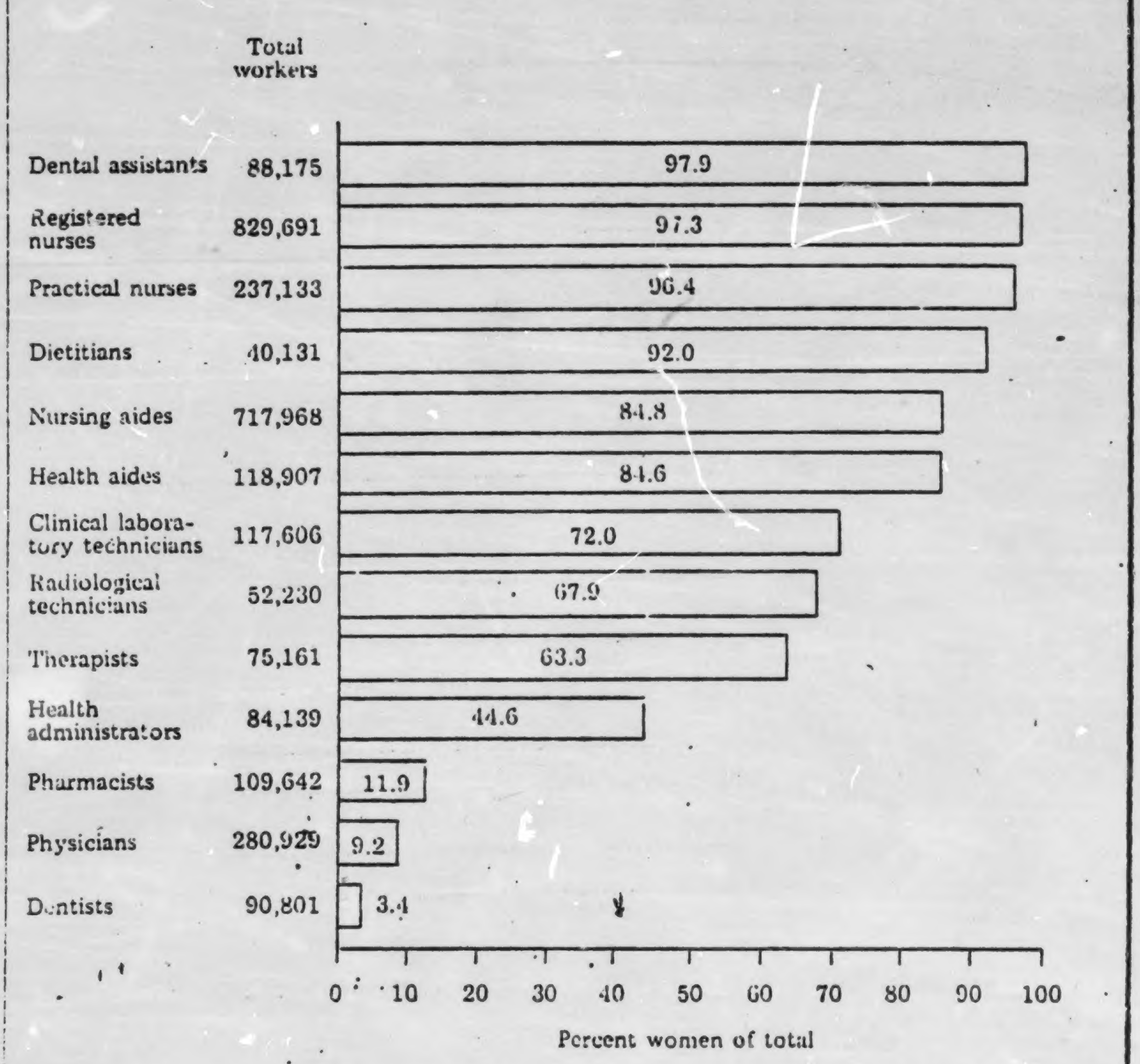
Between 1950 and 1970 the relative importance of employed women increased substantially, from 28 to 38 percent in all industries . . . from 65 to 75 percent in health services.

Figure 2 EMPLOYMENT CHANGES OF WOMEN IN INDUSTRY: 1950-1970



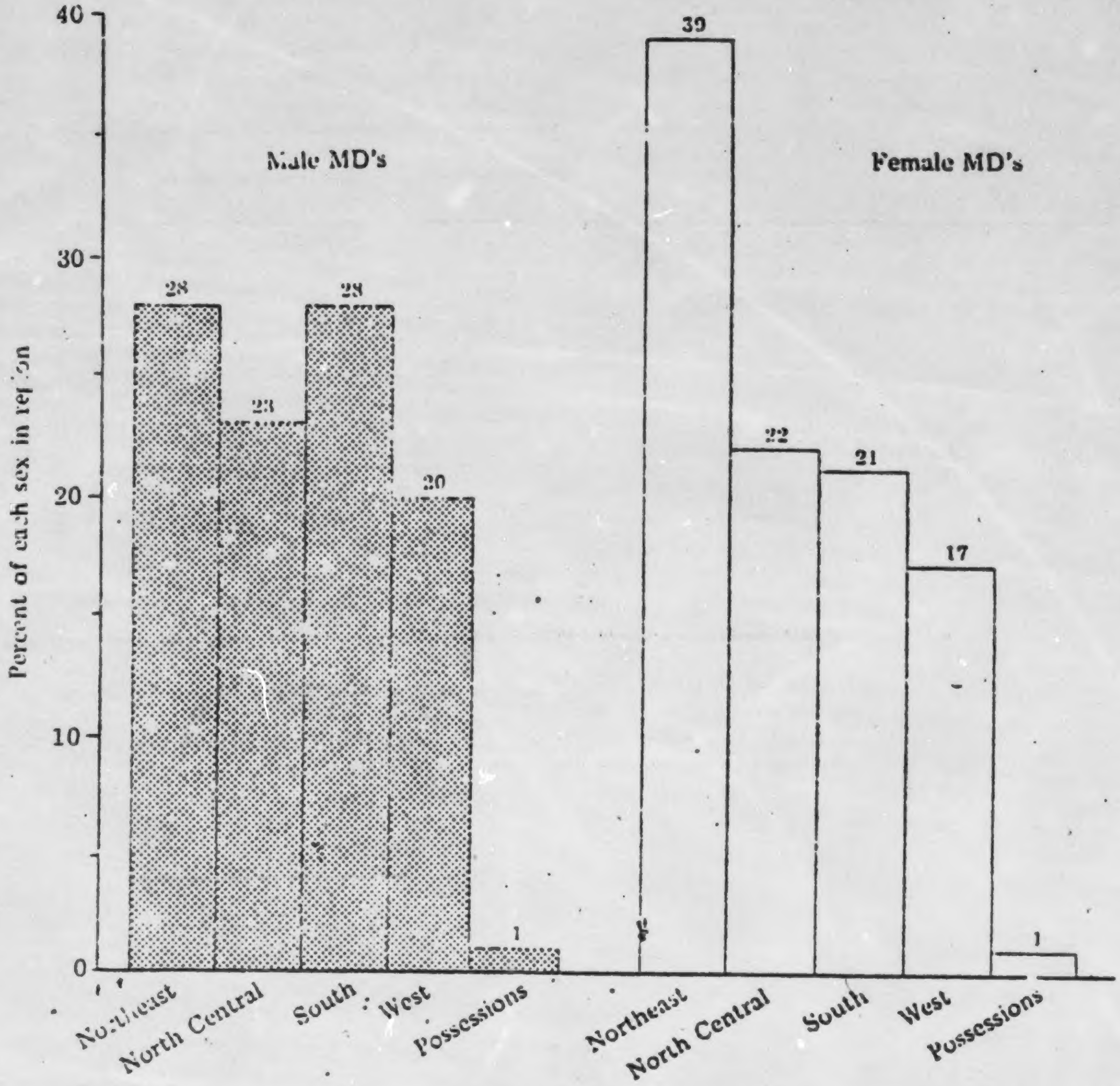
There is a wide variation among health occupations in the proportion of workers who are women.

Figure 3 WOMEN WORKERS IN SELECTED HEALTH OCCUPATIONS: 1970



The Northeast region draws a large proportion of women physicians.

Figure 4. REGIONAL LOCATION OF PHYSICIANS: 1973



Relatively fewer of the physicians in the South and West are women.

Table 4. REGIONAL DISTRIBUTION OF ACTIVE PHYSICIANS (M.D.), BY SEX: 1973

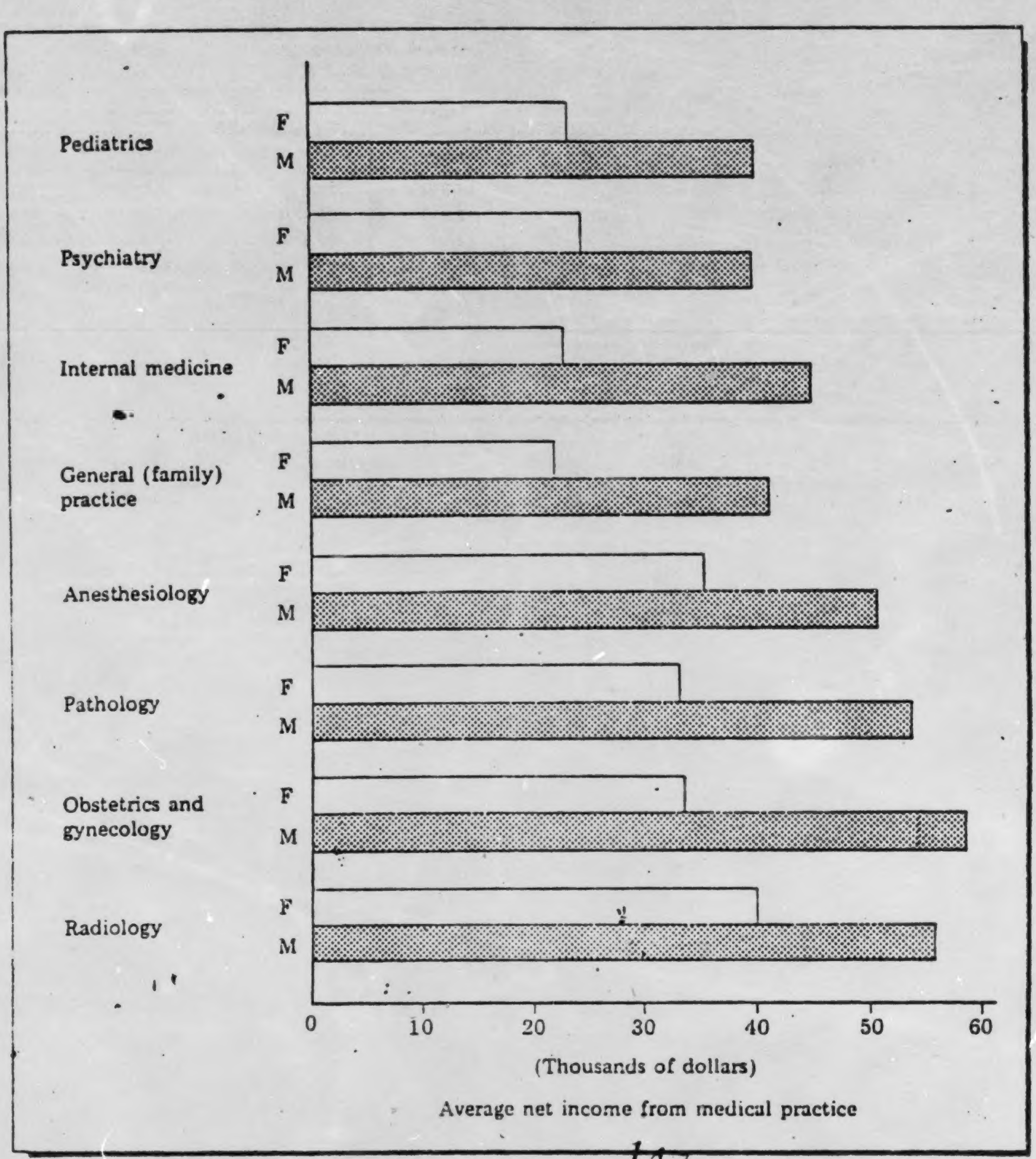
Region	Total	Male	Female	Percent female
	All active physicians			
All regions	324,367	300,013	24,354	7.5
Northeast	93,411	84,003	9,408	10.1
North Central	74,002	68,643	5,359	7.2
South	87,770	82,606	5,164	5.9
West	64,384	60,305	4,079	6.3
Possessions	4,800	4,456	344	7.2
	Federal physicians			
All regions	26,769	25,294	1,475	5.5
Northeast	4,255	3,870	385	9.0
North Central	3,758	3,466	292	7.8
South	10,689	10,193	496	4.6
West	5,913	5,660	253	4.3
Possessions	2,154	2,105	49	2.3
	Non-Federal physicians			
All regions	297,598	274,719	22,879	7.7
Northeast	89,156	80,133	9,023	10.1
North Central	70,211	65,177	5,067	7.2
South	77,081	72,413	4,668	6.1
West	58,171	54,645	3,826	6.5
Possessions	2,646	2,351	295	11.1

Source: G.A. Roback, *Distribution of Physicians in the U.S., 1973. Regional, State, County and Metropolitan Areas*, American Medical Association, Chicago, 1974, pp. 10, 12.

AMA Center for Health Services Research and Development, Special Tabulations on Women Physicians, 1973--AMA Physician Master File (unpublished), American Medical Association, Chicago, Tables 3,7.

The more popular specialties for women physicians have the lowest net income . . . for both men and women.

Figure 5 . INCOME AND SPECIALTY OF PHYSICIANS: 1972



147

Average net income from medical practice in 1972 was $47,945 for men and $27,558 for women M.D.'s. . . .in part related to hours worked.

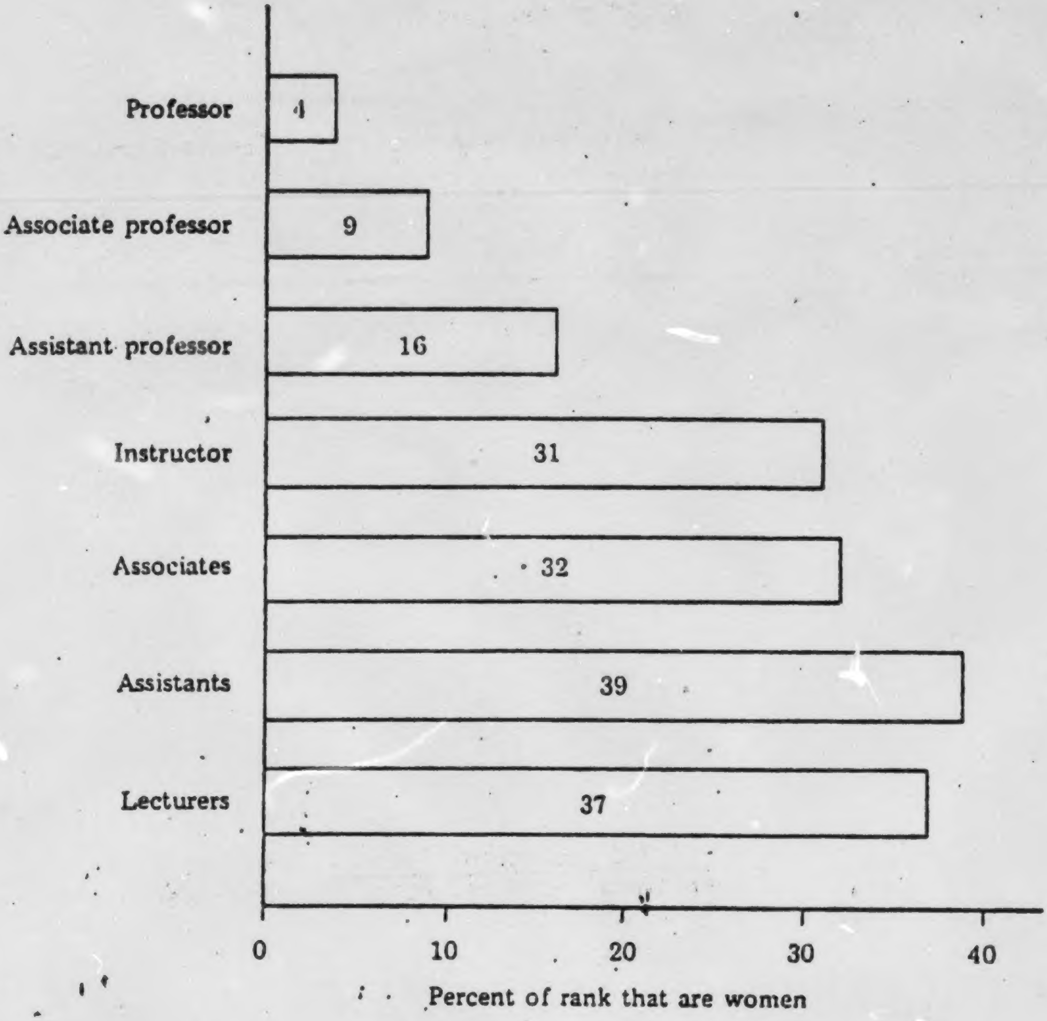
Table 5 INCOME OF AND HOURS WORKED BY PHYSICIANS (M.D.), BY SPECIALTY AND SEX: 1972

Specialty	Average net income from medical practice		Average hours of direct patient care per week	
	Males	Females	Males	Females
All specialties	$47,945	$27,558	46.5	37.4
Anesthesiology	50,898	35,543	48.3	43.5
General (family) practice	41,634	22,339	47.9	39.2
Internal medicine	45,043	23,267	47.5	40.7
Obstetrics and gynecology	53,940	32,864	49.2	37.4
Pediatrics	40,529	23,549	45.8	37.0
Psychiatry	40,433	24,797	40.8	32.1
Radiology	58,891	33,308	41.9	34.9
Surgery	56,377	40,000	48.0	37.8
All other	44,910	27,711	39.7	35.8

Source: B. H. Kehrer, "Professional and Practice Characteristics of Men and Women Physicians," *Profiles of Medical Practice, '74,* American Medical Association, Chicago, 1974, p. 42. Based on sample survey of about 1,400 women and 7,100 men physicians.

Only a small percentage of women hold high academic ranks on medical school faculties.

Figure 6 ACADEMIC RANK OF WOMEN MEDICAL SCHOOL FACULTY: 1971



149

FIGURE 7

MEDICAL SCHOOL FACULTY 1973-1974

(WITH M.D.)

NATURE OF EMPLOYMENT

	Male Physician Faculty	Female Physician Faculty
Strict Full-Time	64%	61%
Geographic Full-Time	21%	19%
Part-Time	15%	20%
TOTAL	100%	100%

Descriptive Study of Salaried Medical School Faculty. prepared by Philip Anderson, Ph.D., Division of Operational Studies, Association of American Medical Colleges, December 1975, Table 31-C, page 72.

FIGURE 8

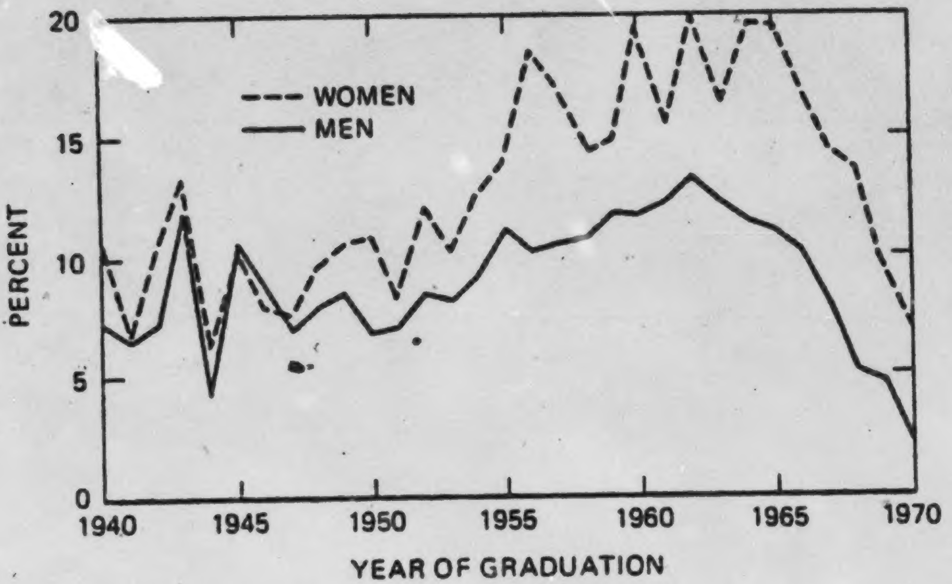


FIGURE 1

Proportions of men and women U.S. medical graduates (classes of 1940–1970) on U.S. medical school faculties in 1975 (full- and part-time, all ranks).

Datagram: Women Physicians on U.S. Medical School Faculties, Journal of Medical Education. Vol. 50, No. 8, August 1975, p. 825.

CONTINUITY AND NONCONTINUITY IN THE CAREERS OF A SAMPLE OF YOUNG WOMEN PHYSICIANS

Lillian Kaufman Cartwright

This paper is based on a program of research in medical education directed by Harrison G. Gough, Ph.D., and carried out at the Institute of Personality Assessment and Research, University of California, Berkeley, under a grant from the Robert Wood Johnson Foundation.

152

CONTINUITY AND NONCONTINUITY IN THE CAREERS OF A SAMPLE OF YOUNG WOMEN PHYSICIANS

Lillian Kaufman Cartwright

When a group occupies a minority status within a profession by reason of its small numbers, there is an inclination to ignore real differences within a group itself and speak of modal characteristics as if shared by all members. Such is the case with women in American medicine.

Numerous surveys[1-5] have documented differences in the career patterns of male and female physicians. Despite lack of comparability and agreement on methodological strategies involving sampling (size, age, geographic area surveyed) and definitions and indices used to assess productivity, the following generalizations can be made: Women physicians gravitate to certain specialties, earn less than men, work fewer hours, are less likely to be board certified, are more likely to be found in salaried positions, and are more apt than men to interrupt their careers.

Role conflict is the accepted explanation for woman's lesser participation in medicine. Society assigns woman the primary role as caretaker of the home and children. Concepts of role strain and role reconciliation have been used to describe the integrative challenges facing women as they bring together the dual responsibilities of professional and family life.[6-8] Contesting the immutability of these societal expectations concerning sex role, Heins et al[9] conclude from their recent survey of highly productive Detroit women physicians that the women are carrying too much of a burden and that a reassessment of child-rearing responsibilities and household management is essential.

Role strain among women professionals and equity between the sexes are of obvious importance. At the same time, individual differences among women doctors in their preferences for specific training patterns and life styles deserve careful scrutiny because of their bearing on multiple problems, including selection procedures, the counseling of young women, and social policy planning. Such information would also provide additional insight into cultural pressures influencing sex-role assignments.

This study investigates one kind of difference among women physicians, continuity versus noncontinuity in training. It asks what specific factors are associated with continuous medical education histories (no gaps in training) and noncontinuous education histories (time taken off during medical school, internship, and/or residency beyond allocated vacations).

Subjects and Methods

The current research is part of a longitudinal follow-up study of over 1100 applicants and graduates of the University of California, San Francisco, School of Medicine conducted by the Institute of Personality Assessment and Research (IPAR) of the University of California in Berkeley. The archival data available on these physicians include personality inventories, biographical data, and academic information. (See Gough and Hall[10] for a further description of the sample, aims, and methods of the study.)

In the late sixties, the author studied 58 women students who entered the San Francisco medical school between 1964 and 1967 (98% of the women then enrolled). The young women came from socially and educationally advantaged backgrounds. Differences in motives for entering the profession were also documented.[11,12]

As part of the longitudinal follow-up in 1974-1975, two to three hour

153

structured interviews were held with 49 of the original sample.* Table 1 describes the sample in terms of personal and professional characteristics.

At the time of the interviews, the women were also asked to re-take two psychological inventories, the California Psychological Inventory (CPI)[13] and the Adjective Check List (ACL)[14] to assess personality changes 8 to 11 years following admission to medical school. Although the personality changes were not great in magnitude, the group differences were in the direction of increased self-confidence and independence as well as revealing increased awareness of nurturant qualities within the self.[15] In addition, the group was well-satisfied with their careers with 88 percent reporting that they were satisfied or very satisfied with their profession. However, as documented by others, the degree of strain accompanying integration of professional and sex roles is moderate to severe for about half the women.

During the interviews, the women were asked whether they took time off during or between any of the following periods in the medical education continuum: medical school, the internship, the residency program. Based on their answers, the women were divided into two groups: The continuous group consisting of thirty women (61.2 percent) and the noncontinuous group comprised of 19 women (38.8 percent).

The great majority of training interruptions (73.7 percent) did not exceed one year. The time between internship and residency was cited most frequently (52.6 percent) as the period of noncontiuity, followed by the residency. Incidentally, only two women took time off during medical school and only one woman is currently unemployed. The reasons for training interruptions were: husband's career and life course (fellowship, draft, job moves), child-birth and early child-rearing, homemaking, leisure, personal illness, and disappointment with a training program (in thatorder).

To see if there were distinguishing characteristics associated with membership in the two groups, two-tail t tests were calculated for four sets of factors: 1) Current situational and professional variables (including marital status, number of children, spouse's occupation, specialty choice, hours worked), 2) Current personality inventory variables (scores on the CPI and the ACL scale), 3) Entry variables (including scores on the Medical College Admission Tests (MCAT), a specialty preference test, and the CPI taken during the first semester of medical school), and 4) Family background variables (derived from author's dissertation[16]).

Results

Table 2 presents the variables that significantly distinguished the continuous group from the noncontinuous group.**

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*Two women in the original sample were omitted from the current research because of death and withdrawal from medical school for personal reasons. A goal of seeing 50 of the remaining 56 was set as reasonable. The interviews were conducted in eight states by the investigator. It should be noted that the Institute, in its large-scale follow-up, is studying a total of 134 women of which 58 are a subsample, comprising only those entering between 1964-1967.

**The complete analysis has been filed with the National Auxiliary Publications Service, NAPS Document No. 03018 order from ASIS/NAPS, c/o Microfiche Publication, 410 Park Ave. South, N.Y., N.Y. 10016.

Current Situational and Professional Variables: The continuous group has fewer children ($p < .01$) and currently are working a longer work week (56.3 mean hours as compared with 40.6 for the noncontinuous group, $p < .05$). None of the continuous group are in general practice ($p < .01$) and no woman who choses a residency in radiology is in the noncontinuous group ($p < .06$).

Among the variables, not significantly associated with either group are: marriage (children appear to be the filter effecting training commitments rather than marriage per se for this sample), whether or not the husband is a physician, age, role harmony,and specialty choices other than the two mentioned above. There is a trend ($p < .08$) for personal ratings of career satisfaction to be higher in the continuous group although both are quite satisfied with their careers.

Current Personality: The continuous group can be distinguished from the noncontinuous on five scales ($p < .05$) of the CPI. This personality inventory is widely used in studies of health professionals and it aims to measure normal personality using "folk" concepts generally accepted in our culture to describe well-functioning individuals. Its 18 scales are readily clustered into four groups: Cluster I addresses interpersonal skills; on these scales the continuous group has higher scores on two of the six scales measuring interpersonal effectiveness (Dominance and Self-acceptance); they are more ascendant and forceful as well as more sure of themselves, the noncontinuous group, relative to general female norms, are not different from women in general on these scales. The continuous group, relative to both their peers and females in general, are considerably more assertive and possessive of leadership qualities. They are extremely self-propelled, confident women. On Cluster II, the scales measuring acceptance of social mores and internalization of conventions, the continuous group,is lower on the Socialization scale (below the mean for female norms) indicating relatively less internalization of conventional mores as well as skepticism surrounding accepted convention. It should be noted that there are no differences between the groups on the scales measuring tolerance and responsibility. The continuous group is thus not unreliable or rebellious in a destructive sense but rather capable of taking an individualistic stance when it challenges personal conviction. There were no group differences on Cluster III which is concerned with intellectual orientations and achievement styles--both groups are intellectually independent and resourceful women. On Cluster IV, those scales measuring interests, two evinced significant group differences: Psychological-mindedness and Femininity. The continuous group is both less "feminine" in respect to traditional expectations and more sensitive to motives and inner life factors than the noncontinuous group. (N.B. the noncontinuouous group is a little above the general female norms for Femininity and considerably above the mean on Psychological-mindedness).

The personality findings suggest that although both groups exhibit a high level of personality functioning and intellectual efficiency, they are indeed different in selected areas: The continuous group is less traditional and less accepting of convention. Their views of sex roles are distinctive, taking issue with concepts traditionally linked with femininity as it applies to themselves (i.e., they are less likely to embrace notions of personal passivity, evince specific "feminine" interests, admit to weaknesses and frailties, and view their sex role as requiring them to be particularly nurturant). In the interpersonal domain they can be expected to be more confident , discerning, assertive, and decisive. They show an astute psychological acuity that considers and values motives, feelings, and nuances of behavior both in themselves and others. The noncontinuous group is more similar to women in the general population with respect to sex role beliefs and attitudes. Such women might desire larger families and be more sensitive to issues involving mother surrogates especially during the first five years of their child's life. They might also be more willing to make personal sacrifices for their husbands' careers. It could be hypothesized, generally, that they would accept subordinate and supportive-expressive roles more readily. They might also choose a different kind of husband whose concept of masculinity encouraged them to take an occasional turn at "altruistic surrender."

The results from the 300-item Adjective Check List support the CPI findings. The women in the continuous group scored higher on Self-confidence, Achievement, and Dominance while those in the noncontinuous group were higher on Abasement. The self-concept of the continuous group is more ascendant and active; the noncontinuous group is more self-critical.

Entry Variables: (a) Medical College Admission Test: The noncontinuous group scored significantly higher on the Quantitative and Science sub-tests ($p < .05$). This is an interesting finding and the author is not sure what to make of it except that it suggests that strong interests and talents in science and mathematics alone will not guarantee continuous training histories, a finding of potential interest to admissions committees who currently are placing considerable weight on achievement indexes and are less sensitive, particularly in women, to the potential role of values and attitudes on vocational decisions.

(b) CPI: The view that personality is an important factor in presaging continuity in training among women, is supported by the entry CPI scores. Two of the scales measuring basic interest orientations, the Psychological-mindedness scale ($p < .05$) and the Femininity scale ($p < .01$), showed significant group differences. In addition, a third scale, Self-acceptance, approached significance ($p < .07$). Recall that when the test was retaken for the follow-up, all three of these scales (plus two more) discriminated the two groups. The women who elected to continue their training throughout all phases, were less "feminine" as measured by this test's concept of feminity and more psychologically astute than their female peers.

(c) Medical Specialist Preference Blank: These scales measuring interest in four medical specialties did not discriminate the two groups.

Family Background Factors: One family typology developed in the author's dissertation showed group differences--the "Father preferred" ($p < .05$). This family constellation was one of five typologies but included only six subjects. The women perceived their fathers as individualistic, intellectual, remote, and somewhat idealized. They preferred him to their mothers for a variety of reasons. Since none of the other background factors were significant, it would be unwise to attach much significance to this finding. Speculatively, this kind of mileau may allow a woman a degree of flexibility in her views about herself and society not obtainable when relationships to parental figures are more defined and conventional.

Summary And Discussion

The data reveal that there are differences between young women physicians who interrupt their training and those who do not. The differences are seen in choices relating to family formation and in personality dispositions. Women having noncontinuous training histories are likely to have more children and be currently in general practice rather than in a specialty. In terms of personality, they are more conventionally "feminine," holding in higher regard the attributes of the traditional woman's role. Those who have continuous training histories work longer hours, bear fewer children, and are more assertive, more self-assured, and more dynamic in their relationships with others. As a group they tend to derive even greater satisfaction from their careers than the noncontinuous group. At the same time, they evince more individuality in their conceptions of sex-role and societal conventions. Most interesting in terms of prediction, is the finding that upon entrance to medical school they were different from the noncontinuous group in respect to their scores on a femininity scale as well as more astute and sensitive to the psychological determinants of behavior. They could be termed more "touch minded" from the start. These findings clearly must be cross-validated on other groups of women physicians because of sample limitations.

Be skeptical about assigning value judgments to the two groups. It would be unwise to conclude that the continuous groups will be more productive as physicians. The impact of early training styles on later career development cannot be determined at this point. Both training styles have advantages and disadvantages depending on who is doing the evaluating, what criteria are invoked, and what point in time the career course is being assessed. The continuous style carries with it more prestige, upward mobility, and economic rewards as well as the rewards of intense, focused attention. The noncontinuous style offers opportunities for lateral development, variety, reflection, and scope in life experiences. Although noncontinuity in career development has been traditionally associated with women because of societal expectations, the future may see men electing this course once freed of pejorative connotations. Dual career families, predicted to be more common in the future, will allow both partners the economic flexibility needed for change in career tempo and direction.

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Table 1

Description of Sample of 49 Women Physicians, Graduates of UCSF School of Medicine, on Selected Variables

Age: mean age: 33; standard deviation: 2.9

Current Marital Status	Number	%
Married	37	75.5
Single	9	18.4
Divorced	3	6.1
Husband is physician	20	40.8
Number having children	20	49.8
Medical Specialty		
Pediatrics	11	22.4
Family Medicine and General Practice (Including Emergency Room)	8	16.3
Internal Medicine	7	14.3
Psychiatry	7	14.3
Radiology	5	10.2
E.E.N.T. Practices	3	6.1
Pathology	3	6.1
Anesthesiology	2	4.1
Dermatology	1	2.0
Public Health	1	2.0
Surgery	1	2.0

Table 2

A Sample of Women Physicians Having Noncontinuous Training Compared With Those Having Continuous Training: Results of t tests on Selected Variables

Variables	Noncontinuous Group (N = 19)	Continuous Group (N = 30)	
Current Situational and Professional Characteristics	Mean	Mean	t#
Number of children	1.16	.30	3.68**
Hours worked	40.58	56.27	-2.52*
General practice (scored 0-1)	.42	0	4.57**
Current Psychological Inventories			
California Psychological Inventory (raw scores)			
Dominance	27.58	30.87	-2.03*
Self-acceptance	21.84	23.90	-2.47*
Socialization	40.00	37.57	2.34*
Psychological-mindedness	13.74	15.00	-2.06*
Femininity	23.79	21.47	2.48*
Adjective Check List: (standard scores)			
Self-confidence	50.00	57.92	-2.35*
Achievement	53.23	60.34	-2.31*
Dominance	51.65	59.19	-2.30*
Abasement	49.06	42.54	2.05*
Entry Variables			
Medical College Admission Test:			
Quantitative	595.53	533.00	2.50*
Science	596.05	558.67	2.17*
Medical Specialty Preference Blank: none significant			

Table 2 (cont'd)

California Psychological Inventory (raw scores)			
Psychological-mindedness	13.11	14.77	-2.50*
Femininity	23.21	20.77	2.93**
amily Background			
Father preferred	0	.20	-2.13*

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* p .05

* p .01

It should be noted that stringency was used in applying the t statistic, taking into account the variance of each group and utilizing separate rather than pooled variance estimates for t when the F value reached significance.

MEDICAL IMMUNITY?

MALE IDEOLOGY AND THE PROFESSION OF MEDICINE

Lynne R. Davidson

A revised version of this paper was presented at the Conference on Culture and Communication, March, 1977. The study reported here was partly supported by U.S. Public Health Service Grant #HS00013.

MEDICAL IMMUNITY? MALE IDEOLOGY AND THE PROFESSION OF MEDICINE

Lynne R. Davidson

The sociology of knowledge posits that modes of thought cannot be adequately understood as long as their social origins are obscured (Mannheim, p. 5, 1936). In fact, most proponents argue that no human thought is immune to the ideologizing impact of its social context (Berger and Luckman, p.9, 1967). How then is it that the "knowledge system" associated with the profession of medicine passes as if it possessed this immunity? Simply answered, medicine is a profession; it is a scientific profession; indeed, it is a male, scientific profession.

This paper accepts the premise of the sociology of knowledge and asserts that the conceptual model and criteria used by social scientists to analyze the medical profession, as well as the actual norms prescribed by that profession, have become a "taken-for-granted reality." Thus, medicine appears to have "ideological immunity."

The first purpose of this paper is to suggest that the formal normative prescriptions of the professional, such as "affective-neutrality" and "universalism," are embedded in and reflect legitimations of the vested interests of male ideology. The second is to show that several of these "taken-for-granted realities" of how doctors treat patients, i.e. the normative premises about medical practitioners and the criteria used in the model of professionals, are simply not actualized empirically. Serious question is raised as to whether deviation from male-linked formal normative structure may not enhance, rather than deter, the service rendered by a profession.

A third purpose, although of somewhat lesser significance, is simply to explore and provide an overview of several other more informal and subtle realms which also reflect the stringent inculcation of male-dominated ideology in medicine. For example, discussion is addressed to the problems of colleaguial networks and role models, physicians' typifications of patients and of one another, the "tracking" of women into "female-linked" specialties, and the role of the linguistic devices.

Thus my major concern is to raise several of the significant issues which to date have been largely ignored theoretically. My assertions are based on findings of an empirical study which do not support the taken-for-granted image of medicine and hence led me to question it. The data were derived from a comparative study of 96 men and women physicians-in-training (49 women and 47 men) conducted in a large metropolitan hospital in New York (Davidson, 1975). Although the data were collected in an earlier phase of the woman's movement (1969), implications for reassessment of the assumptions in the medical/professional model clearly apply today. While changes have occurred in various sectors of society as a result of the woman's movement, the model of the professions has been extremely resistant to change. What are the components of this model?

Masculinity and the Medical/Professional Model

Medicine has long been stereotyped as a male profession and is clearly dominated by men (Becker *et al*., 1961; Davidson, 1975; Epstein, 1970; Hall, 1975; Lopate, 1968; Lorber, 1975). However, the general conceptual model used to analyze the profession has remained relatively free from scrutiny of sex-role bias. With the exception of Lorber's short and incisive discussion of "The Masculine Mystique in American Medicine," virtually no systematic criticisms have been levied against the sex-role ideology implicit in the traditional model.

The model of professions proposes numerous components to characterize medicine and to distinguish it from other occupations of less prestige and "scientific" acclaim. And although the literature is replete with criticisms and proposed modifications (Hall, 1975; Roth, 1974; Roth, Ruzek, and Daniels, 1973), there exists strong consensus regarding the nature of these components (Freidson, 1973; Goode, 1960; Greenwood, 1957; Hall, 1975; Parsons, 1955; Siegler and Osmond, 1976).

Following the earlier work of Parsons, the professional model views the prescribed role of the medical practitioner as universalistic, functionally specific, affectively neutral, and based upon values of achievement, technical competence, and collectively orientation. As Lorber noted: "Except for collectivity orientation--the one variable that separates the professional from other kinds of occupational roles--these pattern variables add up to the group labelled 'instrumental.' 'Instrumental' roles in our society have been associated not only with science, but also with work in general, and therefore with masculinity, both in the sense of masculine values and of masculine behavioral norms." (Lorber, pp.90-91, 1975). The question remains: do the values and norms hold up in clinical practice? Not insignificantly, Parsons equates these prescribed roles with the "predominant pattern" of professionals in American society. He, thus, treats the prescribed, normative assumption "as if" it were an empirical, factual reality.

Examination of other components of the model reveal equally masculinist values. Professionals devote "central life interest" to their work. This means that the occupational status is supposed to have high priority commitment over the traditionally defined female domestic/family status (Orzack, 1963). Professionals have authority over clients, autonomy, control and power (Freidson, 1970,1973; Greenwood, 1957; Hall, 1975; Siegler and Osmond, 1976). Indeed, Siegler and Osmond have adopted Patterson's concept of "Aesculapian authority" to refer to medical professionals because their position is one of "...unusually powerful authority" (Siegler and Osmond, p. X , 1976). The essence of the analytic framework which Eliot Freidson uses to distinguish the occupational principle (professional) from the bureaucratic principle (nonprofessional) is the degree of control over work which the individual has (Freidson, 1973). According to Richard Hall the overriding social reason for the importance of professionals is: "Professionals have power" (emphasis Hall's, Hall, pp.70-71, 1975).

Most simply, I question whether these value traits, i.e. power, control, and autonomy, would have become prominent components had the model of professions been constructed by feminists, or indeed, even a nonfeminist woman?

The professional model also makes assumptions about the "homogeneity" of professionals (Ritzer, 1973) and the importance of "identification" with colleagues (Vollmer and Mills, 1966). Paradoxically, "latent social identities" (Gouldner, 1957-58) or the personal and demographic characteristics of a professional are supposed to be irrelevant in the performance of a universalistic role. Given the demographic profile of medicine, which is largely comprised of white Anglo Saxon males, assumptions of "homogeneity" and "identification" with colleague certainly tend to preclude easy realization by women and members of ethnic or other minority groups.

One need only examine the demographic characteristics of most sociologists who specialize in the area of professions to understand why assumptions of the model and analytical schema perpetuate. Like medicine, the sociology of occupations and professions is highly dominated by men. Thus, on the meta level, another coat of gloss is added: the reality which is constructed is doubly embedded in a male ideology and reflected as both a phenomenon and an epiphenomenon. (Again, I must reaffirm that this assertion rests on the premise that all modes of thought, even the sociology of science, are subject to ideologizing impact of the social context.)

My own belief as to the reason why more critical theory has not developed to analyze professions rests with the sociologist's own identification as a professional. To the extent that the sociologist challenges or criticizes the professional model and respective assumptions of achieved power and control, then he demystifies male ideology and dethrones himself as a professional. A revisionist model which is more egalitarian could well lead to abdication of power and control over one's own work.

Modes of thought such as Cooley's "sympathetic introspection" or Weber's "verstehen" have no place in the positivistic model of the medical profession. Indeed, a physician who claims that diagnosis or treatment is based upon intuition or affective involvement with a patient is subject to immediate reprimand and sanction by colleagues. The colleaguial control system itself is legitimated by "imputed expertise" based on rationalistic, scientific, and allegedly objective knowledge. Traits of subjectivity, expressivity, affectivity, and particularism, which are traditionally female-linked, are viewed as counterthematic to the model of the medical professional. As Parsons stated simply:

> Affective neutrality is also involved in the physician's role as an applied scientist. The physician is expected to treat an objective problem in objective, scientifically justifiable terms. For example, whether he likes or dislikes a particular patient as a person is supposed to be irrelevant, as indeed it is to most purely objective problems of how to handle a particular disease. (Parsons, p.435, 1955)

At this point some empirical data will help to assess the accuracy of the model and the extent to which the accuracy varies by sex.

Affectivity vs. Affective Neutrality

Several findings from a comparative survey which I conducted on men and women physicians-in-training are relevant here. Many of the items in the research were designed specifically to tap a wide range of different kinds of affective (and affectively neutral) experience of physicians-in-training such as sympathy, depression, anger, and purposive avoidance of involvement with patients. Affects were classified as positive or negative (Arnold, 1970; Lock, 1957; Lenrow, 1965; Plutchik, 1962; Strongman, 1973; Rosenberg, 1956; and Young, 1973). In order to tap performance data on actual behavior, physicians were asked to cite specific incidents which involved different affects and to comment on relevant categories such as intensity and frequency of past occurrence. A primary aim of this research was to examine the extent to which sex differences of the physician might account for variance in affective performance as professionals. Accordingly, men and women in the sample were matched on the three potentially confounding variables of medical specialty, rank, and ethnicity.*

The included Table presents responses to affect items by sex of physician and shows that women physicians tend to be more affective in general than men physicians in their professional role with patients.

A striking feature is that women measure greater affect on *all* items designated as positive affect, although a wide range of variation appears in levels of statistical significance. With respect to positive affects, the three items which are statistically most significant show that women, compared to men, are extremely sympathetic and drawn toward patients (.002), actually enjoy involvement with patients more (.01), and do not attempt to avoid involvement (.04) to the extent that men do. With respect to negative affects, women have a greater likelihood of depression (.01) and frequency of upsets (.004); whereas men tend to show slightly higher annoyance/anger although this latter difference is not statistically significant. These findings of difference between men and women physicians in performance of their professional role parallel stereotypical sex-linked traits--i.e., sympathy, emotional involvement, and depression/upset are female-linked; annoyance/anger are male-linked (Broverman, *et al*., 1972; Chafetz, 1974; Epstein, 1970; Freeman, 1971; Macoby and Jacklih, 1974). Most important, *neither* men nor women physicians are as "affectively neutral" or "objectively detached" as the medical or sociological model of the professions alleges (Greenwood , 1966; Hall, 1975; Lopate, 1968; Parsons, 1955).

Findings also cast doubt on arguments made by earlier research that control of affects such as sympathy and involvement arise from the physician's conviction that such controls are conducive to the patient's welfare and desirable as a normative regulation for attainment of professional objectives (Daniel, p.263, 1960). Rather, data suggest that physicians do *not* endorse the norm proscribing affective involvement to the extent that the model implies, although this holds true to a somewhat greater extent for women than men. Equally significant, data revealed that physicians' evaluation of the desirability of affect was based on their own *particularistic* needs and not simply *universalistically* determined needs of the patient. Likewise, affective experiences and behavior of physicians were *expressive* releases, not *instrumental* maneuvers employed as therapeutic devices to control the patient.

The question of ultimate importance for the medical or any other profession is a question of evaluation. Does deviation from the traditional ideology enhance, deter, or have no effect on the ultimate service and function rendered by that profession?

According to physicians in this sample, affects designated as positive tend to enhance rather than deter the interpersonal aspects of patient management and, although to a lesser extent, the actual medical treatment delivered. The reverse was said to be true for negative affects. For example, with virtually no sex differences, 87% of men and women physicians felt they

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*The sample consists of 96 men and women physicians-in-training in a large metropolitan hospital in New York. Given the relatively small number of women physicians at the research hospital, the study was designed to include the entire universe of women physicians at the hospital, excluding only those women who were interviewed during exploratory field work. A stratified sample of men equal in number to the women was chosen, matched on the variables of ethnicity, rank, and medical specialty of the physician. Male subjects included in the final "matched pair" were randomly selected from the total number of males within each respective category.

Percentage Positive and Negative Affect of Physicians Toward Patient by Sex of Physicians

	Sex	
POSITIVE AFFECT	Male	Female
1. Intensity of Sympathy		
a. extremely/very	22.2	55.1
b. fairly/little	51.1	36.7
c. none	26.7	8.2
	(45)	(49)
		X^2=12.27
		sig.= 0.002
2. Many Patients Sympathetic/Drawn to		
a. yes	45.5	63.0
b. no	54.5	37.0
	(44)	(46)
		X^2= 2.14
		sig.= 0.14
3. Personal Enjoyment from Emotional Involvement		
a. yes	50.0	77.1
b. no	50.0	22.9
	(46)	(48)
		X^2= 6.34
		sig.= 0.01
4. Endorsement of Desirability of Involvement		
a. definitely/very desirable	13.3	21.7
b. qualified desirable	60.0	63.0
c. undesirable	26.7	15.2
	(45)	(46)
		X^2= 2.38
		sig.= 0.30
5. Avoidance of Involvement		
a. no	39.5	63.0
b. yes	60.5	37.0
	(43)	(46)
		X^2= 4.02
		sig.= 0.04

(Cont.)

	Sex	
NEGATIVE AFFECT	Male	Female
1. Likelihood of Depression if Patient Dies		
a. very likely/likely	48.9	75.0
b. a bit likely/ not at all	51.1	25.0
	(45)	(48)
		X^2= 5.68
		sig.= 0.01
2. Frequency Actually Feels Depressed		
a. very frequently/frequently	17.0	28.6
b. occasionally	51.1	53.1
c. seldom/never	31.9	18.4
	(47)	(49)
		X^2= 3.18
		sig.= 0.20
3. Frequency of Actual Upsets		
a. frequently/occasionally	38.3	69.4
b. seldom/never	61.7	30.6
	(47)	(49)
		X^2= 8.13
		sig.= 0.004
4. Intensity of Anger/Annoyance		
a. extremely	8.7	2.2
b. very	19.6	26.1
c. fairly	54.3	41.3
d. little	17.4	30.4
	(46)	(46)
		X^2= 4.68
		sig.= 0.19
5. Frequency of Anger/Annoyance		
a. once a week or more	28.9	19.1
b. once a month or more	37.8	36.2
c. less than once a month	33.3	44.7
	(45)	(47)
		X^2= 1.68
		sig.= 0.43

had acted differently toward patients they especially liked, in a way that enhanced either the calibre of medical care of the interpersonal relations between doctor and patient. Similar results were found in cases where the physician felt extreme sympathy toward a patient and again there were no differences between men and women. Thirty-eight percent reported that they attended more to interpersonal aspects of patient care, and another 50% acknowledged that they gave better medical care as well as attended more to patients' personal needs.

Such findings, coupled with the physicians' frequently reported refusal to endorse the proscription against involvement with patients, suggests that physicians do not really perceive the affective-neutrality component of the model to be pragmatically functional. Additional evidence that physicians sometimes engage in what I term "subjective identification" further underscores the particularism which occurs in the clinical realm of medicine.

Physician Subjective Identification with Patients

A content analysis was used in this research to determine, from the physician's own perspective, the kinds of contextual circumstances which elicit or elaborate affective experiences. Without going into detail about the numerous circumstances examined, I will here briefly allude to findings on "subjective identification" of the physician with patients. The meaning of this concept is similar to what psychologists refer to as "counterference" or "projection" on the part of the doctor and represents an extreme example of the professional taboo against particularism and subjectivity. In this study, subjective identification was coded whenever physicians described their affective experiences by using phrases such as "I felt like the mother/father of the child" or "we were the same age and nationality." In other words, the concept refers to identification with a patient based on the perceived similarity of the physician with the personal attributes or social origin of the patient.

Following are a few illustrations of the finds of subjective identifications which occurred:

(sympathy incident - male physician)

> Those nine-to-eleven-year-old boys I was telling you about--you really feel for them! I might be projecting a lot, but especially those nine-to-eleven-year-old boys who are members of a minority group. I was a boy, too, and as a second-generation Italian I know how they feel. When I was nine or ten, was real depressed about being Italian. I didn't like that my skin was darker than most of the other kids. While we spoke English in the family, the Italian background came out in many ways. And when I was nine or ten my father gave me a book to read on the unification of Italy, and it did a great deal for me.

The empathic response of this physician to young boys of minority status clearly emanates from his own particular social origin as a young Italian boy. Another physician disclosed that familial resemblances, the nature of the illness, and the socio-economic status of the patient partially accounted for differences in his affective responses. This physician generalized about patients who elicit his greatest sympathy with the following statement:

> ...patients who remind me of my mother--to be more general, patients who remind me of people in my past, I can identify with.
>
> There was one lady with breast cancer. She was a woman of the same social-economic class as I am, and I emphathized more than I ordinarily would. There is a parallel because my sister has something in her breast and I hook the two up. I had been in (affiliated hospital) before, and hadn't seen that many middle-class, so there's a much stronger association here.

A woman physician who described her most upsetting experiences, emphasized age as a crucial element of her identifications.

> With any young person, you identify with them, and when they get a sudden, fatal illness, I suppose you think that you could get it too. But really it's more because I feel sorry for them. I don't care when old people die; in fact, I'm glad because they're too much trouble.

Another physician, quite unaware of his personal predispositions prior to the interview, stated simply:

> Always I feel extremely sympathetic to the late forties. I seem to have this thing about the forties group. There is so much I am finding out about myself in this interview.

Quantitatively, data showed that "subjective identification" occurred with 24% of the total sample in depression/upset incidents; 28% in sympathy/drawn to, and only 1% in anger/annoyance. Approximately half of these physicians actually used the phrase "identified with." These figures are surprisingly high, given the fact that the percentages were extrapolated from personal accounts offered by physicians without interviewer probing on this item and given the explicit counter-normative nature of identification to the medical model. In fact, I strongly suspect that such figures are a conservative estimate.

Only minimal differences exist between men and women physicians in the extent to which subjective identification is associated with the different kinds of affect incidents. However, a meaningful inference can be drawn from the fact that the sex differences, although slight, occur in reverse direction in depression/upset (men 19.6%; women 29.8%) and sympathy/drawn to (men 32.6%; women 24.4%). From this, we can surmise that the process of identification per se is not sex-specific or particularly endemic to women physicians.

Findings on subjective identification of the physician vividly portray the particularistic bases of the enacted role of both men and women. What a physician does and feels seems to be as much a product of the subjective definition which the physician brings to the situation as it is of any objective system which is based on universalistic criteria. Overall, the findings of this study reaffirm a basic premise of the systemic relationship between the subjective predisposition of an actor, the social origins of that actor, and the particular situational context in which s/he acts. By no means does the professional have "ideological immunity."

Julius Roth, in Timetables, has aptly noted that "Patients are always finding differences between what they expect to happen and what actually happens, and over a period of time one can detect shifts in their norms to make these norms correspond more closely with reality (or at least with a selected portion of reality)" (Roth, p. 10, 1963). The norms of the patient are characteristically informal in comparison with the highly formal norms of the physician. Nonetheless, disparity between the formal norms, the enactment of those norms, and their endorsement, suggests a need to shift formal norms so that they adhere more closely to the "reality" situation--to realign prescribed roles to better fit enacted roles.

Despite the evidence that physicians, in general, are shifting norms to accomodate greater positive affect, women physicians do not yet fully recognize the value of their own sex status in this respect. Current changes in the social and self-definitions of sex roles leave women physicians uncertain as to the medical value of traditional female traits. For instance, when women in the sample were asked to state the main advantages and disadvantages of being a woman doctor, many women gave contradictory replies. More than a third of the women reported the main advantage was that the feminine qualities of sympathy, emotional involvement, and maternal tenderness enhanced the doctor-patient relationship and medical care. For this reason, they reported that patients often preferred women physicians. Other women, though fewer in number, were of the opinion that these same female-associated attributes were disadvantages for a woman physician. These women felt that the prime obstacle to overcome was the patients' negative impression of women as emotional and too affective. The very lack of consensus and conviction among women in evaluation of their sex-associated traits shows how stringent is the male ideology in medicine.

The time is long overdue to reassess and reevaluate the extent to which the present norms of the medical profession are reasonable avenues for accomplishing the goals of medicine; moreover, we must determine if those norms accomodate as well as guide our physicians. An increasing number of minority groups--women and foreigners--are entering the profession of medicine. A major finding of this research is that differences in latent social identities among these groups, and even among specific individuals, result in personal differences in their role performance as physician. How well a patient adopts a sick role depends, as we know, on cultural, social, and personal differences. Why is it so difficult to accept that the way a physician adopts his or her role also is dependent on these same conditions?

I have discussed in detail illustrations of how male ideology is reflected in the formal model of the profession and how physicians deviate from that model in patient care. What are some of the other ways in which ideology is exemplified and perpetuated?

Other Realms: Subtle and Pervasive Forms

The informal organization and unofficial communication network in medicine is as male dominated as is the formal organization (Hall, 1975; Lorber, 1976). There is an elaborate informal structure of male influence in recruitment, grant allocation, and sponsorships. As Lorber noted:

> Selection of proteges takes place among a group who are relatively homogeneous by universalistic standards of academic performance. Within this group, the search for future colleagues is made on the basis of particularistic qualities, such as ethnic origin and religion. (Lorber, p.82, 1976)

There is simply no "inner sorority" within medicine to compete with the powerful influence of the exclusionary "inner fraternity." Women physicians-in-training give higher value to the social category "female physician" than do men physicians (Davidson and Koenig, 1973). Despite this, however, there is still evidence that women have somewhat negative impressions of other women physicians as a social category. After respondents reported their general impressions of women physicians, several of the women commented, "But I'm different." Surprising and disheartening is the fact that the majority of women in the sample reported strong preference for working with men colleagues. The fact that men also preferred men colleagues was not, however, surprising.

Devaluation and status differentials are intricately related. A male intern adamantly expressed that he simply did not like working with women physicians, but added:"...I guess it would be different if I were a resident and she were an intern."

Women physicians also view the male patient as both the problem and the preference. In other words, women overwhelmingly reported that they preferred to treat men patients rather than women, even though they reported that all major problems which they encountered with patients were with men not women patients. Thus, part of the informal everyday working male ideology involves value "typifications" of "self," "patient," and "colleague." These typifications have become "taken-for-granted realities" which do not necessarily reflect grounded empirical experience. Even though women physicians tended to devalue themselves as well as be devalued by men colleagues and patients this does not necessarily mean group disparagement exists as described in earlier research work (Epstein, 1930). A more palatable interpretation is that a simple lack of esprit de corps. Without any "ideal role models," women have a sense of group uncertainty and individual separateness regarding "where" and "how" to fit into the general schema of medicine. Medicine has virtually no guidelines or norms to accomodate personal differences among physicians, especially sex differences. And so, the women repeat: "But I'm different! " and often aim to imitate male doctors.

The lack of role models for women physicians is a crucial factor in accounting for the maintenance and perpetuation of male ideology in both the formal and the informal structure. The primary institutionalized avenue for the dissemination of "knowledge systems" is education. Women do not occupy high-ranking university teaching positions; moreover, there is not a single deanship occupied by a woman physician in this country (Witte, 1976). This of course precludes visibility of women as role-models in medical education. More significantly it means that men solely control the content of what is taught, decision processing, and curriculum planning.

The task is to solidify an "inner sorority," to develop esprit de corps among women, and to create influential role models within the power structure of the mainstream of medicine. However, women physicians must be careful not to accept "ghettoizing" suggestions which serve the ideological function of detouring and deflecting them away from power positions. Often the blatant male-protective ideology is couched under the guise of helping women ease role strain. As Hall commented in the recently revised critique of the professions: "There are certain situations that help the woman professional in adjusting to the strains in the role. If a woman shares statuses other than sex with her colleagues, as in the case of...a female black dentist who practices in the black community, colleagues and clients alike will likely be less resistant (Hall, 120, 1975). I am reminded here of Goffman's observation that in a mental asylum the punitive device of "solitary confinement" in symbolically legitimated by substituting the phrase "constructive isolation." The "constructive isolation" of black women physicians with "like" clientele can mean nothing other than low prestige clients and a devaluation of professional prestige (Lorber, 81, 1975; Walsh and Elling, 1968).

It is well known that women are overrepresented and clustered in specialties which are the least prestigious, The claim that this kind of clustering is a function of the sex-role compatibility of the tasks which the specialty entails is among the major explanations offered.

The basic tenet of the task compatibility position is that certain specialties function as institutionalized avenues for reducing role conflict; the specialties lessen the distance between the sex and medical roles, and hence reduce potential contradiction in the woman's self-image (Kosa and Coker, 1965). Epstein (1970) and Quadagno (1976) correctly point out the fallacy in this logic, since role compatibility based on the nature of a task by no means erases the role conflict which may arise from sheer time demands. Elsewhere in an article entitled "Choice by Constraint," 1977, I argued that the compatibility argument is based on a traditional definition of sex-linked traits and reinforces rigid sex-role typifications of specialties. In turn this functions as a "symbolic universe of legitimation" (Berger and Luckman, 1967) and as an institutional rationalization to perpetuate existent male ideology. In other words, the compatibility argument serves to remind women that there are a few places in medicine for them, but not too many (Davidson, 1977).

A conference was designed not long ago with the specific purpose of increasing opportunities for women physicians. It was titled: "Meeting Medical Manpower Needs." Even more striking, the announcements of new women officers of the Women's Medical Association which were reported in the summer 1976 edition of JAMWA used the phrase "chairman." These examples illustrate the subtle role of semantic/linguistic devices in communicating and maintaining male ideology.

To return to the perspective of the sociology of knowledge, ideologies are often embedded in what Berger and Luckman call "conceptual machineries" which function as "sheltering canopies" of a particular interest group. Such machinery can take the form of single words, such as "chairman" or "manpower," or an entire analytical framework such as the model of the medical profession. In this paper I have attempted to show that male-linked assumptions of the medical model, such as objectivity and universalism reflect "taken-for-granted realities" which do not necessarily hold up in empirical reality. Berger and Luckman state:

> Institutions and symbolic universes are legitimated by living individuals who have concrete social locations and concrete social interests...symbolic universes and all legitimations are human products; their existence has its base in the lives of concrete individuals, and has no empirical status apart from these lives. (Berger and Luckman, 128, 1967)

Findings on particularism, subjective identification, and affectivity of both men and women physicians in this study support the validity of such a statement. Without serious re-evaluation of the formal and informal organization of medicine, the prognosis for women physicians remains grim, male ideology will perpetuate, and the profession will continue to act "as if" it has its own "medical immunity."

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VII.

BROADENING THE PICTURE: OTHER ISSUES AND CONCERNS

Moving women into positions of leadership and authority involves many complex social, psychological, cultural, and political factors. In this section, we present abstracts of previously published work or work in progress discussed by conference participants, which address a wide range of issues and concerns.

Lipman-Blumen's research on achievement motivation is classic. Bucher and Stellings' recent comparative study of socialization in four health profession specialties sheds new light on the programming effects of training programs. Lorber examines the career contingencies of women doctors in "conforming" and "deviant" specialties. Wilkerson discusses a program designed to identify women for leadership positions in higher education administration. Henley and Johnson offer insights into how women's leadership behavior is linked to gender roles. Handy suggests that researchers need to examine the conditions under which minority women are hindered in moving into positions of leadership and authority and what the consequences are which are associated with the dual status of being a minority and a woman.

Three studies on the historical roles of women in medicine and nursing by Walsh, Bullough, and Ver Steeg provide background on how women have fared in the arena of professional politics over the years.

VICARIOUS AND DIRECT ACHIEVEMENT PATTERNS: A TYPOLOGY AND UNDERLYING DYNAMICS

Jean Lipman-Blumen and Harold J. Leavitt

Lipman-Blumen, Jean, and Leavitt, Harold J., "Vicarious and Direct Achievement Patterns: A Typology and Underlying Dynamics," Draft of a work in progress.

This paper presents a typology of direct and vicarious achievement patterns conceptualized as orientations toward accomplishing goals. Three direct achievement modes—intrinsic, competitive, and instrumental—are presented by which individuals strive through their own actions to achieve their desired goals. Three vicarious achievement modes—altruistic, contributor, and instrumental—also are discussed by which individuals attempt to meet their needs indirectly through the agency or actions of other individuals with whom they identify. A model of the underlying dynamics of these achievement orientations is presented and an achievement-sexuality scoring system is described for steering adults into traditional sex-linked occupations.

Jean Lipman-Blumen is the Director, Women's Research Program, National Institute of Education. Ph.D., Harvard Graduate School of Arts and Sciences.

BECOMING PROFESSIONAL

Rue Bucher and Joan G. Stelling

Bucher, Rue and Stelling, Joan G., Becoming Professional, Sage Inc., 1977.

The basic tenet of our conceptual framework is the interaction of structural and situational aspects of a training program which is largely responsible for the professional characteristics of the graduates of that program. The data demonstrate that there is a "programming effect"—i.e., that the outcomes of socialization are, in large part, determined by the nature of the training program. A brief summary of findings follows bearing on the existence of the programming effect and the ways in which the programs operate to constrain and shape the development of their trainees. This is followed by discussions of: 1) the most important elements in the development of professional identity and commitment; 2) the apparent contradiction between the programming effect and the active involvement of socializees in the construction of their own identities; 3) the interplay between structural and interactional variables and the construction of a "theory of professional socialization." The chapter concludes with a discussion of some of the broader implications of the findings, particularly for the construction of professional training programs and the accountability of professions.

Rue Bucher is a Professor of Sociology, University of Illinois, Chicago Circle. Ph.D., University of Chicago.

WOMEN AND MEDICAL SOCIOLOGY:
INVISIBLE PROFESSIONALS AND UBIQUITOUS PATIENTS

Judith Lorber

Lorber, Judith, "Women and Medical Sociology: Invisible Professionals and Ubiquitous Patients," work in progress.

I am trying to bring to bear Hall's concept of the inner circle or inner fraternity as it shapes medical careers, Hughes' concept of colleagueship as a loyal brotherhood, and my own notions of conformity and deviance in conventional (conformist) work settings on the question of women doctors. I see women doctors as deviants but some (surgeons) are more deviant (double deviants) than others (pediatricians). I am interested in tracing the processes by which the forces of inclusion into and exclusion from informal work groups shape the careers of women doctors. Some of these ideas were developed in "Women and Medical Sociology: Invisible Professionals and Ubiquitous Patients" (in Millman and Kanter, Another Voice, Doubleday Anchor, 1975) and also in "Trust, Loyalty, and the Place of Women in the Informal Organization of Work" (to be published in second edition of Freeman, Women: A Feminist Perspective).

Judith Lorber is an Associate Professor of Sociology, Brooklyn College, City University of New York. Ph.D., New York University.

NATIONAL PROGRAM TO ADVANCE WOMEN IN HIGHER EDUCATION ADMINISTRATION

Margaret B. Wilkerson

Wilkerson, Margaret B., "National Program to Advance Women in Higher Education Administration."

There is a paucity of women in higher education administration. Because of this fact, the higher education community suffers a loss of intellectual talent, a loss of potential leadership, and a loss of female role models for students and other professionals. The critical problems facing higher education demand the best talent available. The higher education community cannot afford to have competent women administrators minimally involved in policy determination.

The Office of Women in Higher Education of the American Council on Education has inaugurated a National Identification Program for Women in Higher Education Administration. This project, funded by the Carnegie Corporation and the Exxon Education Foundation, will be the central effort during the next three years by which the Office of Women will address its primary goal of advancing women who have shown promise for major positions in administration.

Implementation of the National Identification Program is intended to result in the establishment of a personalized system of identification, recommendation, and advancement of women administrators and in an increased number of women who have prominence in higher education. The program has initiated a carefully constructed state or regionally-based system which will seek to establish a national network of women and men interested in developing a firm system of equality of opportunity.

A Career Advancement Seminar designed to identify potential women administrators for major posts, to increase the knowledge and visibility of such women, and to understand and overcome personal barriers to their advancement was recently held. The participants had the opportunity to discuss critical major issues which confront higher education, especially in California, and to propose solutions or strategies that they, as major administrators, might pursue. The seminar was also structured to aid in the development of a state-wide support network for women administrators, to create strategies for effecting change and coping with institutional barriers, and to identify mentors, both men and women, who are interested in the advancement of women in this field.

Margaret B. Wilkerson is Director, CCEW - Women's Center, University of California, Berkeley, and the California State Coordinator for the National Identification Program for Women in Higher Education Administration, Office of Women in Higher Education, American Council on Education, Washington, D.C. Ph.D., University of California, Berkeley.

NONVERBAL COMMUNICATION AND THE SOCIAL CONTROL OF WOMEN

Nancy M. Henley

Henley, Nancy M., "Nonverbal Communication and the Social Control of Women," Science For The People, (July):16-19.

Nonverbal communication is put forward as a massive but hidden form of social control that particularly affects women. Women are socialized to be more susceptible to such subtle control; are integrated around centers of power, necessitating such interaction with the powerful; and are more sensitive to nonverbal cues than are men. Examples are given of nonverbal dominance signals emitted by men and submission signals returned by women. A general pattern is that signals of dominance (used unilaterally in an unequal relationship) are also used to convey intimacy (used mutually in an equal relationship). Thus a gesture of power from a man toward a woman may masquerade as one of friendship; or conversely, when women use the symbols of power, they are often taken as sexual signals. Nonverbal behavior occupies the point between covert and overt social control, and covert and overt resistance to control. Much of women's "passive" behavior may result from a sequence in which assertion was attempted, and suppressed, on the nonverbal level. Nonverbal communication is seen as a link between the micropolitical (personal dominance) and macropolitical (large-scale power), basic to women's understanding of power and their relation to it.

Nancy Henley is an Associate Professor of Psychology, University of Lowell, Lowell, Massachusetts. Ph.D., Johns Hopkins University.

WOMEN AND POWER:
TOWARD A THEORY OF EFFECTIVENESS

Paula Johnson

Johnson, Paula, "Women and Power: Toward a Theory of Effectiveness," Journal of Social Issues, Vol. 32, 1976.

This paper develops a theory of sex-role stereotyping and power use in terms of how people interact in daily life situations. Power use is proposed to be affected by sex-role stereotypes on three major dimensions: direct-indirect, concrete-personal, and competent-helpless. It is demonstrated that women have less access, in reality and in expectations, to concrete resources and competence, leaving them with indirect, personal, and helpless modes of influence. Power use is examined in terms of sex-role stereotypes, and data are presented which support the hypothesis that people expect males and females to use different bases of power.

Paula Johnson is a consultant at Rand Corp., Santa Monica, California. Ph.D., University of California, Los Angeles.

DOUBLE POSITIVE/DOUBLE NEGATIVE

DILEMMA OF THE MINORITY FEMALE MANAGER IN HEALTH AND ELSEWHERE

Gladys Handy

Handy, Gladys, "Double Positive/Double Negative: Dilemma of the Minority Female Manager in Health and Elsewhere," work in progress.

Handy suggests that researchers have generally limited their questions to whether or not it is better to be a minority woman (vs. white woman, white male, or minority male) without considering other significant possibilities. She asks: What are the logical consequences of the dual status of being a minority and a woman? Four possibilities exist: 1) That the dual status combination is always positive; 2) That the dual status combination is always negative; 3) That sometimes it is race which is the more positive or negative, sometimes it is sex which is more positive or negative, and sometimes the combination is what is most important; 4) That there are some circumstances under which it simply does not matter. The key question therefore is: What are the institutional constraints and conditions under which minority women are hindered in moving into positions of leadership and authority, and what are the special problems associated with the combined status?

Gladys Handy is the former Deputy Commissioner of Higher Education, State of Pennsylvania, and a consultant in social science and education.

DOCTORS WANTED: NO WOMEN NEED APPLY

Mary Roth Walsh

Walsh, Mary Roth, Doctors Wanted: No Women Need Apply, Yale University Press, 1977.

The "golden age" of women physicians in the United States occurred in the late nineteenth century. At that time women made up ten percent or more of the enrollment in eighteen regular medical schools across the country. Moreover, the progress of female physicians paralleled the increase in the professionalization of medicine. Why, then, are there so few women physicians in the United States today? Drawing on a wide variety of unexplored primary material, Mary Roth Walsh shows that the all-male medical establishment made a conscious effort to limit the number of women physicians. From both psychological and economic motives men tried to deny equal access to medical careers.

The feminist movement, offering support for women who were breaking from their prescribed roles, was the crucial instrument of progress for nineteenth-century medical women. But Walsh shows that women physicians were effectively opposed because they were unable to exert any real power in medical institutions. As the woman's rights movement directed its energies toward gaining the vote, women physicians could do little more than protest the establishment of a quota system for medical school admission. Analyzing the current situation, Walsh warns that, unless women gain some degree of power in the profession, the recent dramatic increase in their admission to medical schools may go the way of their earlier gains.

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196

BARRIERS TO THE NURSE PRACTITIONER MOVEMENT: PROBLEMS OF WOMEN IN A WOMAN'S FIELD

Bonnie Bullough

Bullough, Bonnie, "Barriers to the Nurse Practitioner Movement: Problems of Women in a Woman's Field," International Journal of Health Services, Vol. 5, No. 2, 1975.

Barriers to the nurse practitioner movement are explored in this article. Historically, the subordination of women and the sex segregation of nursing and medicine have helped to establish interaction patterns between the two professions which included a subordination of nurses as well as informal doctor-nurse games. These patterns were reinforced by hospital training schools and state laws which restricted the roles of nurses. Recent changes in state licensure and educational reform in nursing are now facilitating the nurse practitioner movement, but the stereotyped communication patterns between nurses and physicians remain as a barrier to the full use of the talents of nurses in practitioner roles.

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THE POLITICAL PROCESS, OR,
THE POWER AND THE GLORY

Donna F. Ver Steeg

Ver Steeg, Donna F., "The Political Process, or, The Power and the Glory," from Bollough, B., The Law and the Expanding Nurse Role, Appleton-Century Crofts, 1975.

This paper shall consider the power and the glory of the political process as it applies to all citizens and professions; but we will illustrate it with examples from ongoing research in health manpower legislation. Insofar as this can be construed as a "how-to" paper, it shall include some comments on the particular problems of women and of nurses in politics, also drawn from ongoing research.

Although professions exist because of a mandate from society to perform certain functions, and many professions operate under legislative sanctions, there is a tendency among the rank and file members to forget this fact.

Although in the past it was not considered very professional to be involved in the political process, it is now a professional necessity. This paper will deal with methods of assessing power and influencing the political process.

Donna Ver Steeg is Assistant Professor of Nursing, University of California, Los Angeles. Ph.D., University of California, Los Angeles.

VIII.

DIFFERENT STRUCTURES OF LEADERSHIP AND AUTHORITY

The traditional organization of the health care professions is a highly stratified, pyramid-shaped structure with power exercised from the top downward. Many organizations today are experimenting with more egalitarian forms of governance where the opportunity for decision making is spread more evenly throughout the structure.

Estler and Davis describe the "filter points" in the traditional hierarchical structures which make women's movement into positions of leadership and authority difficult. Mansbridge's study of decision making in an alternative, nonhierarchical health care setting raises provocative questions about women's assumption of leadership roles.

201

WOMEN IN DECISION MAKING

Suzanne Estler

This paper was developed with assistance from Cynthia Davis, Research Assistant, Center for Research on Women, Stanford University.

WOMEN IN DECISION MAKING

Suzanne Estler

Women are rarely represented in top level decision-making roles. Less than one-half of 1 percent of chief executive officers of large corporations, about 1 percent of top civil service officers, 3 percent of high school principals, and about 3-1/2 percent of college and university presidents are women (see Table 1). Women's representation rises to somewhat more than 10 percent in a few high-level occupations, such as elementary school principal, board member and chief executive of non-profit organizations, and state secretaries of state. In none of these occupations, however, do women represent more than one-fourth of the total.

These numbers do not suggest that women have no decision-making power. Women make decisions in the home, the classroom, the community, and often exert their influence behind the scenes upon male decision makers. But the public decision-making arena is significantly more limited for women than for men, so that women seldom have access to the level of decision making which influences large numbers of people or the overall direction of society.[1] An example of this type of influence, from which women are largely excluded, is a decision to raise the price of steel, which can affect rates of inflation, unemployment, and consumer access to products. The recent Food and Drug Administration decision to ban the use of saccharin is a similar kind of example of the decisions made at the highest levels of government, business, and industry which affect individuals of both sexes, every social stratum, and every ethnic group.

We do not suggest that the world would change dramatically with an increase in the numbers of women decision makers at top levels. Women are no more infallible than men. However, there are several good reasons to support an increase in the number of women decision makers in our society:

1. Equity: Our nation is legally and morally committed to the premise that each person, regardless of race, sex, religion, or national origin, has a right to equal opportunity in all levels of employment,

2. Optimal use of talent: Human talent is a national resource. The potential of one-half the population is wasted when women are excluded from the top levels of decision making,

3. Quality of decisions: Because women's acculturation and experiences are often quite different from men's, women can provide alternative perspectives and supplemental information for the decision-making process,

4. Quality of organizational climate: When organizations increase the number of women in decision-making positions, several unanticipated benefits often accrue. For example, open recruitment and promotion procedures often result in increased opportunities and attendant improvement in employee morale for men as well as for women.

Top-level decisions have been made, for the most part, by a homogeneous group of Caucasian, upper-middle or upper class males. It is the limited number of women at this highest decision-making level which concerns us in this paper.

Most research on women in decision making has focused on specific sectors: business and industry, unions, education, politics, government or non-profit organizations. In this paper, we use existing research to generalize about patterns common to all sectors. We are interested not merely in describing the numbers of women in top positions, but in analyzing the processes by which top positions are filled. Thus, we are looking not only at women in top management, but also at those in lower and middle management, since experience at these lower levels is essential to upward mobility and access to top-level executive positions.

After considering statistics which show where women are in top and mid-level positions, we will develop the concept of organizational filter points. We think of filter points as screens between the various structural levels of an organization. These screens permit some personnel to move in an upward direction while holding others at their current job level. In order to identify barriers to the upward mobility of women, we will look at the major factors which determine the filter process: competence, the compatibility between individual attributes and organizational needs, and the role of a mentor or sponsor. Once we understand the operation of the filter process, we will be in a better position to recommend steps which would accelerate the movement of women into top decision-making positions.

Our first task, then is to return to the statistics with which we began.

General Observations

The figures shown in Table 1 indicate that women are infrequently found in top level decision-making positions. As we have noted, in most areas they fill fewer than 4 percent, and never more than 25 percent of these positions. When the middle and lower levels of management are added to our statistics, women's representation is still low. In 1974, although women constituted 40 percent of the labor force, they were only 18.5 percent of all employed managers and administrators.[2] Nevertheless, it is clear that women's representation at lower and middle management levels is far greater than at the top management level. Something appears to occur in the filter process between levels which systematically reduces the number of women at each succeeding level. Some more specific patterns regarding women in decision-making are illuminated by the following research observations:

.The proportion of women in top jobs is likely to be higher in small organizations than large.[3]

.There are proportionately more women at higher levels in organizations which employ many women.[4]

.In organizations which do not necessarily employ many women, those women who reach higher levels are often in roles demanding skills traditionally attributed to women, e.g., Vice President of Personnel vs. Vice President of Finance.[5]

.Across sectors, there appears to be proportionately more women in top jobs in the West than in the rest of the country.[6]

.Those women who are in top jobs are likely to receive fewer rewards than their male counterparts, as evidenced in lower salaries and fewer fringe benefits and perquisites.[7]

.They are somewhat less likely than male counterparts to be married.[8]

.They are likely to be older at time of promotion to the top job than male counterparts.[9]

204

.They are somewhat more likely to have attained the position at least partially as a result of family ties.[10]

.They are more likely than male counterparts or other women to have had a working mother.[11]

.They are more likely than other women to have the support and approval of family and friends for pursuing a career.[12]

The following section will consider some of the causes and implications of these observations in the context of general career mobility patterns.

Upward Mobility Patterns and Filters

The pattern of upward mobility in organizations is illustrated in a very general way in Figure 1. The figure shows a series of managerial levels connected by filter points. To gain entry to each successive level, an individual must pass through the screening process or filter, represented by hiring and promotion procedures. Some organizations have more managerial levels than others and important decisions may occur at all of these levels; however, most all organizations are characterized by some structural hierarchy of responsibility with ultimate authority resting at the top. Arrows in the figure show that positions at a given level may be filled in three ways: 1) Through promotion from lower levels within the organization; 2) Through lateral transfer from another unit at the same level and, 3) Through recruitment from outside the organization. In order to locate the barriers to the upward mobility of women, we need to understand the critical factors in the screening process.

We can divide the elements which enhance the chances for promotion or hire into three categories: competence, compatibility, and the influence of a mentor.

1. Competence: A person's competence may be evaluated according to a number of criteria: academic credentials, professional training (e.g., MBA, Ed.D.), on-the-job training, performance in previous jobs, and demonstrated managerial skills. The assessment of competence generally becomes more difficult at each ascending managerial level. At lower and middle levels, jobs usually require the organization of people and work to meet specific, defined, organizational goals. However, at higher levels, where policy is made, responsibilities cover a broader span and are less clearly defined. Such jobs often require response to a complex set of circumstances existing both within and outside the organization. In the absence of concrete, goal-related measures, readily observable factors such as race and sex may be used unconsciously as a proxy for assessing competence. In the face of uncertainty, familiar characteristics are reassuring to those who operate the filter points.

2. Compatibility: This category refers to the match of individual attributes and the needs of the organization. These attributes may include skills and age. At a given time, the organization might, for example, be facing financial constraints. Promotion will then favor those with accounting and budgeting skills. Since sub-units at a given level tend to specialize by skill, there may be several promotions from one sub-unit at a given level and a few or none from another. Further, organizational needs may differ by managerial levels. Skills enhancing promotion at one level may be irrelevant at another.

Age is also a factor in compatibility. A person who is much younger than those at the level of promotion may provide a threat to colleagues or may be perceived as having inadequate experience. On the other hand, an older person may be seen as a poor investment for the formal and informal training that comes with promotion.

If there are inadequate candidates from within the organization to meet needs at a higher level, then the number of hires from outside will increase. This is likely to occur if the organization expands its goals, increases in size, or shows trouble in meeting existing goals.

3. Mentorship: A mentor can serve two functions for the lower level manager--those of advocate and educator. The evaluation of competence is difficult. When a trusted higher-level manager attests to the quality of a candidate, this personal input facilitates the task of evaluating the candidate's paper qualifications. Further, the training offered by the lower-level manager provides very real skills which add to qualifications for promotion.

Barriers to Women

The data discussed earlier show that the higher the level of management, the lower the representation of women. This systematic decrease is illustrated more specifically in Figure 2, which presents the proportions of women at various levels of higher education. Those proportions decrease markedly after each successive filter point, a pattern consistent with most other occupational sectors.[13] What are the ways in which this filter process limits women's upward mobility?

Competence: Women are often at a disadvantage as they approach organizational filter points because of deficiencies in previous training. Having been counseled to avoid certain "less feminine" disciplines, women may lack skills in science and mathematics which are considered desirable in managerial roles.[14] But even when women have acquired the necessary skills, they have had a difficult time establishing their competence. In most sectors women managers report the necessity to work harder to prove their competence.[15] Other studies report assumptions on the part of both men and women that women are less likely than men to be competent managers.[16] This creates a situation in which, until proven otherwise, men are assumed competent and women assumed incompetent. Thus, while the exceptionally competent male is likely to be given signals for high expectations; the comparable woman is generally not. For women, this often has the psychological effect of a self-fulfilling prophecy. Moreover, the talented woman is less likely to receive the concrete training that often accompanies high expectations. Assumed less competent, the woman may simply remain invisible to her superiors in a situation where visibility is important to success.

Compatibility: Women's limited training in science and math often serves to decrease their chances of a "fit" with organizational needs at higher levels, needs which are perceived to require hard skills. There appears to be an assumption that those who have hard skills can acquire the soft skills associated with interpersonal relations but not vice versa. Returning to Figure 2, we see that in higher education women are primarily in positions requiring interpersonal skills, those associated with student services. Very few women appear, however, in areas presumably requiring hard skills, such as budgeting and research administration.

Age serves in two ways to limit the upward mobility of women. If a woman is young, the organization may be hesitant to invest in the training necessary for promotion on the assumption that she will leave for marriage and family. If she is older, she may be considered beyond the age when training will be of long-range benefit to the organization.

In relation to entering one of the filter points from other organizations, societal prejudices regarding the outside organizations where many women typically receive leadership training create another barrier for women. The term "volunteer" carries a stigma. Thus, even the unpaid volunteer who manages a sizable budget and a large professional staff may receive no "career credit" for managerial skills she has developed and is rarely viewed as a suitable candidate for career management positions in the paid sector of the economy.

Mentorship: For a number of reasons, men at higher levels are often hesitant to adopt a woman in a mentor relationship. Some suggested reasons include the search for "someone like me"--usually defined, at least partially, as male; the perceived or real potential for a sexual relationship; the fear that a woman may be less serious in her commitment to her career than a man; and the previously mentioned assumed lower competence.

Solutions

It is apparent that each of the factors operating at organizational filter points potentially limits the upward mobility of women. The concept of filter points does indeed make existing data more understandable. For example, the lower proportion of women at higher levels of large organizations vs. small ones makes sense since a large organization is likely to have more filter points. In addition, the concept of filter points suggests specific strategies for change.

With regard to competence, programs could be initiated in educational systems to change the nature of academic and career counseling for both girls and boys. Further, within organizations, training programs could encourage women to develop new skills, as well as teach them to utilize existing skills. In particular, there is no reason to assume that hard skills cannot be acquired. The higher motivation likely to accompany access to a new career in fact enhance the learning process. Moveover, organizations might recognize a broader range of skills in screening for promotion or hire. There is, for example, no reason to believe that the skills associated with student personnel administration would not be useful in higher levels of university administration. Finally, promotion policies might give attention to the concept of critical mass. Management can increase the confidence of women and assure their visibility by distributing them to maximize the development of mutual support networks.

Some of the solutions listed above would also serve to increase the compatibility of a particular woman's skills with organizational needs. There are also specific solutions to the problems of age. It is possible, for example, to assure a return on the training of younger women by encouraging continued work during the child-bearing years. These might include child-care facilities, options for part-time work, and take-home work. It should be noted that organizational commitment to training, with the possibilities it provides for future promotion, is in itself an incentive for the younger woman to stay with the organization. Provision could also be made for the training of older women resuming a career. There is no reason to assume that the peak productivity cycles are identical for men and women. The training provided a 40-year-old woman is likely to benefit the organization for at least 20 years. These may encompass her years of peak productivity.

The effects of the "volunteer" stigma on transfer from other organizations can perhaps best be eliminated through practice. As experience shows that the management skills acquired in a large volunteer organization are just as valuable as those gained in business, perhaps the volunteer sector will finally be recognized as a legitimate leadership training ground.

There are ways, too, of reducing some of the current negative effects of the mentor system on women's mobility. The existing ambiguities could be reduced by formalizing the relationship, for example, through an administrative internship program assigning mentors to selected candidates. Another program might provide multiple mentors to a group of women allowing access to a diversity of skills without the perceived risks of a one-to-one relationship. An increase in the number of women at higher levels will provide an additional source of mentors for lower-level women.

The implementation of any of these solutions requires attention not only to women but to men in the organization as well. Corresponding programs for men are necessary in order to reduce potential male resentment and possible disruption in the organization. Emphasis in the education system on new roles for men is just as important as increasing options for women; organizational programs teaching soft skills to men are just as important to their future success as programs teaching hard skills for women. The ultimate goal, of course, is to teach skills to people, regardless of sex, which will enhance the quality of their work and work situation.

These solutions are necessarily very general, as existing research is woefully inadequate. A good training program is rare. An effective program is built on solid information. To design better training programs, we clearly need a great deal more research to identify the critical problems, assess the potential effects (both intended and unintended) of alternative solutions, and evaluate the many programs already in operation. Interdisciplinary research centers, such as the Center for Research on Women at Stanford University, provide an important means for linking academicians interested in these problems with the organizations dealing with them on a day to day basis.

The need to bring women into top decision-making positions, the ways of furthering that goal, and the benefits which will ultimately ensue from women's upward mobility as decision makers have been presented in this paper. We believe that the beneficial changes suggested will be significant not only for women, but also for men, for organizations, and for society in general. But such change will not take place without determined efforts in all national sectors: business, industry, unions, education, government, and private philanthropy.

The recent recognition of women's exclusion from top decision-making positions is part of a broad social and economic change in men's and women's roles. The active interest of private philanthropy in these changing roles can have profound impact on the very future of our society.

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Table 1

WOMEN IN DECISION-MAKING: REPRESENTATIVE DATA

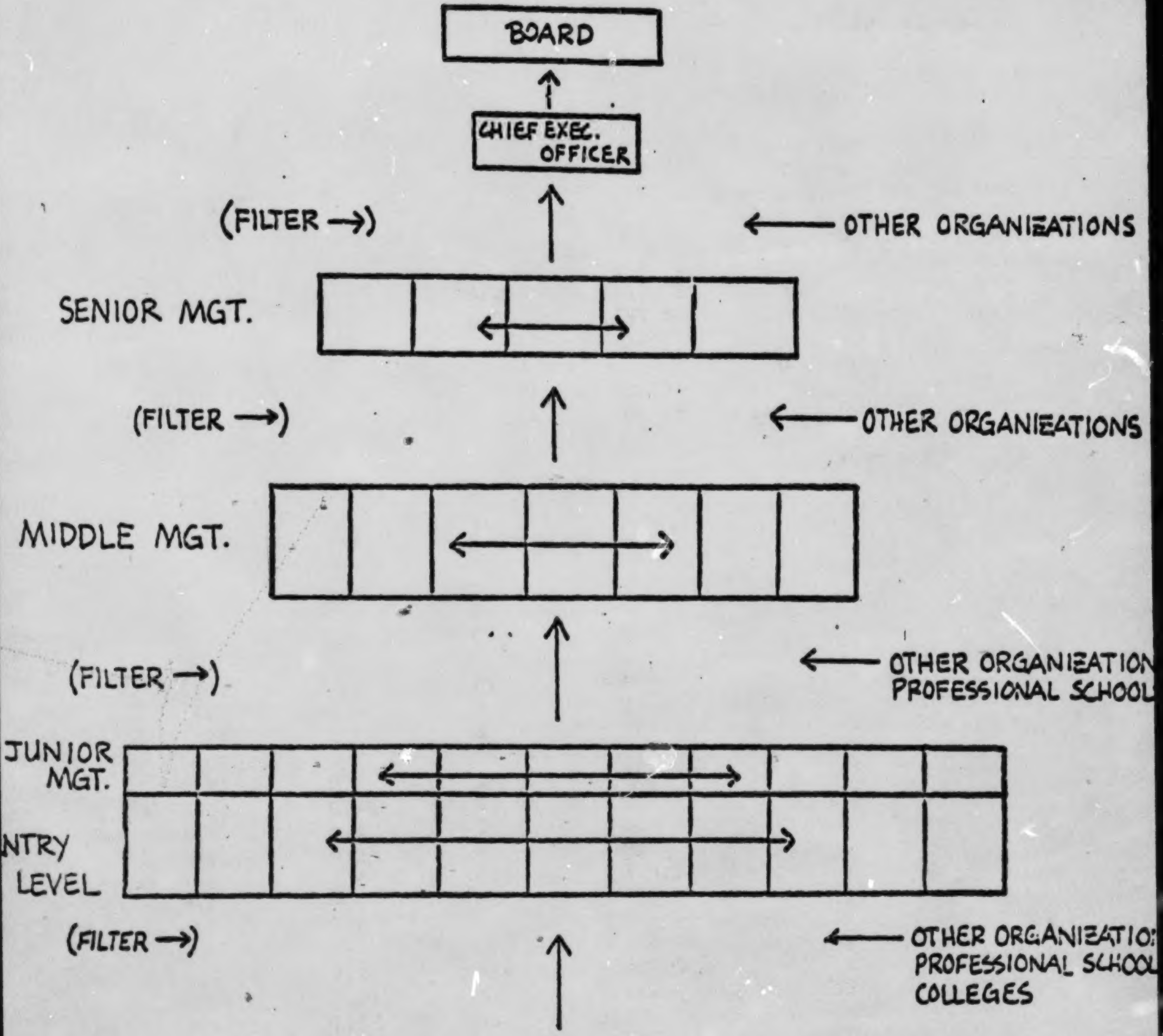
POSITION	TOTAL NUMBER	NUMBER OF WOMEN	PERCENT OF WOMEN	YEAR	SOURCE
Corporations					
Chief Executive Officer (CEO) (Fortune 500 firms)	500	1	.2	1976	1
Directors	*	ca. 200	*	1975	2
Unions					
President, National Unions	177	2	1.1	1972	3
Higher Education					
President (4-year Institutions)	953	32	3.4	1971-72	4
Exec. Vice President (4-year Institutions)	217	5	2.4	1971-72	4
CEO (2-year Institutions)	523	3	.6	1971-72	4
Elementary and Secondary Education					
Superintendent	14,379	90	.6	1970-71	5
High School Principal	13,763	414	3.0	1970-71	5
Junior High Principal	8,782	310	3.5	1970-71	5
Elementary Principal (Includes teaching Principals)	47,714	10,041	21.0	1970-71	5
Members, School Boards	ca. 96,560	11,000	11.4	1975-76	6
Federal Government					
Cabinet Officers	11	2	18.2	1977	
Civil Service: GS 18 and above	1,837	24	1.3	1970	7
Politics					
Federal:					
U.S. Senate	100	0	0.0	1977	8
U.S. House of Representatives	435	18	4.1	1977	8
Supreme Court Justices	9	0	0.0	1977	
Federal Judges	675	8	1.2	1975	9
State:					
Governor	50	2	4.0	1977	8
Secretary of State	50	12	24.0	1977	8
Treasurer	50	2	4.0	1977	8
Lt. Governor	50	3	6.0	1975	9
Senate	1,978	102	5.2	1977	8
House of Representatives	5,583	583	10.4	1977	8
Non-Profit Organizations					
**Board Members	2,794	636	22.8	1975-76	10
**Board Officers	474	90	19.0	1975-76	10
**Executive Directors	94	21	22.3	1975-76	10
Foundation Trustees	3,476	664	19.1	1976	11

*Data not available

**Greater Boston Area, excludes Foundations

FIGURE 1

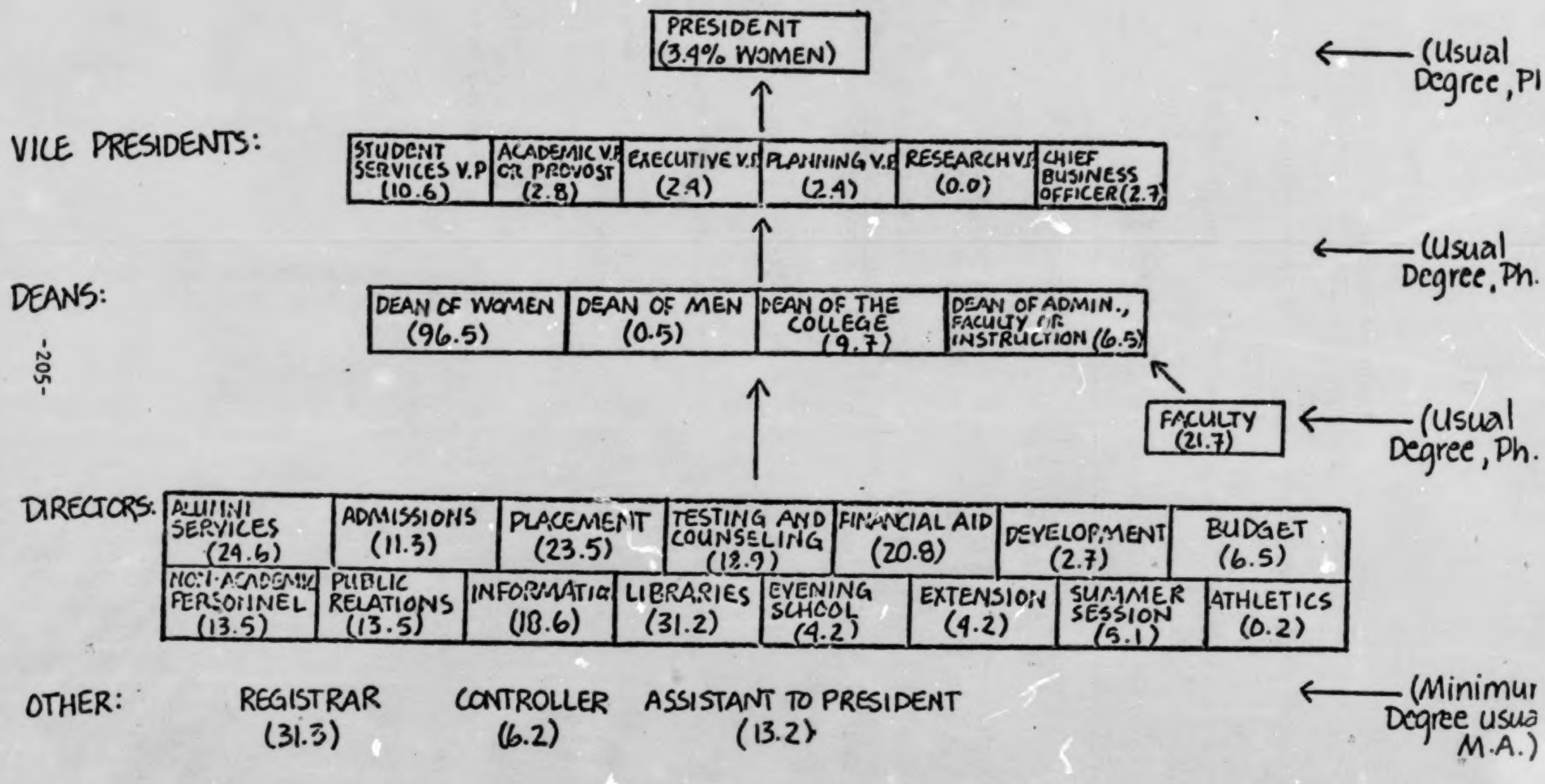
CAREER MOBILITY CHANNELS


BOARD
CHIEF EXEC. OFFICER
(FILTER →)
OTHER ORGANIZATIONS
SENIOR MGT.
(FILTER →)
OTHER ORGANIZATIONS
MIDDLE MGT.
(FILTER →)
OTHER ORGANIZATION
PROFESSIONAL SCHOOL
JUNIOR MGT.
NTRY LEVEL
(FILTER →)
OTHER ORGANIZATIO
PROFESSIONAL SCHOO
COLLEGES

Non-Professional Ranks

FIGURE 2

CAREER MOBILITY: HIGHER EDUCATION, WITH PROPORTION OF WOMEN AT EACH LEVEL (FOUR YEAR INSTITUTIONS)


PRESIDENT (3.4% WOMEN)
(Usual Degree, Pl
VICE PRESIDENTS:
STUDENT SERVICES V.P (10.6)
ACADEMIC V.P OR PROVOST (2.8)
EXECUTIVE V.P (2.4)
PLANNING V.P (2.4)
RESEARCH V.P (0.0)
CHIEF BUSINESS OFFICER (2.7)
(Usual Degree, Ph.
DEANS:
DEAN OF WOMEN (96.5)
DEAN OF MEN (0.5)
DEAN OF THE COLLEGE (9.7)
DEAN OF ADMIN., FACULTY OR INSTRUCTION (6.5)
FACULTY (21.7)
(Usual Degree, Ph.
DIRECTORS:
ALUMNI SERVICES (24.6)
ADMISSIONS (11.3)
PLACEMENT (23.5)
TESTING AND COUNSELING (12.9)
FINANCIAL AID (20.8)
DEVELOPMENT (2.7)
BUDGET (6.5)
NON-ACADEMIC PERSONNEL (13.5)
PUBLIC RELATIONS (13.5)
INFORMATION (18.6)
LIBRARIES (31.2)
EVENING SCHOOL (4.2)
EXTENSION (4.2)
SUMMER SESSION (5.1)
ATHLETICS (0.2)
OTHER:
REGISTRAR (31.3)
CONTROLLER (6.2)
ASSISTANT TO PRESIDENT (13.2)
(Minimum Degree usua M.A.)

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FOOTNOTES

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[1] Minorities too are generally excluded from this type of decision-making power. We will focus on women as the largest excluded group and the one for which the most data are available. An understanding of the process by which women are excluded will, we hope, have relevance for all groups.

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[illegible]3 Minorities and Women in State and Local Government, 1973. U.S. Summary, Vol. I. Washington: U.S. Government Publications.

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"Making a Lot of Noise"
PROBLEMS OF WOMEN'S LEADERSHIP IN A PARTICIPATORY DEMOCRACY

Jane J. Mansbridge

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Helpline began in 1967 to help the flower children who poured into one American city that summer. Over the next six years, it developed a set of services that the area still requires--a twenty-four hour crises counselling hotline; a short-term, in-person counselling service; an emergency medical van; and a runaway house. Helpline supports itself through a mixture of grants and contracts that change from year to year. Several hundred volunteers do much of the work, but the core staff consists of forty-one individuals, aged nineteen through thirty-seven, only a few of whom have formal degrees in counselling.

A "revolution" in 1971 deposed the charismatic founder of the organization and established a participatory democracy, first based almost entirely on a general assembly of the whole, and later on a system of representative committees. From the beginning, all staff members took the same salary with standard increases for dependents and special increases for cases of particular need. They also tried to spread power equally. Eighty-nine percent of the staff checked on a questionnaire that they thought "equality of political power in internal decisions" was "very crucial" or "fairly crucial" to making the organization what they wanted it to be.

Helpline decentralized most of its decisions to five small work groups of six to twelve members, each of which made its decisions by consensus, in a procedure which allowed for "going along with the group" except when one was firmly convinced of the rightness of one's objection. The group as a whole decided large questions of policy in day-long or weekend meetings, called "Community Days," while two committees made smaller, weekly decisions. When either of the committees could not reach unanimity or whenever a member of a committee suspected that there might not be unanimity among the community as a whole on any issue, the representatives took that issue back to the work groups, which discussed the problem until they arrived at a consensual decision.

The staff's commitment to equality and the elaborate institutional apparatus for spreading participation did not, however, produce complete political equality. There was room in the organization for leadership and for some members to become more interested in administration than others. Characteristics that derived from the organization--the length of time one had been there or proximity to the central building--influenced the degree to which each member participated in matters dealing with Helpline as a while, was judged as powerful in those matters by the others, and judged her or himself as powerful. Characteristics like age and class that the members brought with them into the organization also influenced participation and power. Race and sex had less impact on power and participation than longevity, geographical proximity, age and class (see Table I). The political salience of race and sex in 1973 had encouraged the dominant groups at Helpline, the whites and males, to avoid obvious domination and the subordinate groups, the blacks and females, to struggle against their own lower participation. The disadvantages of blacks and women at Helpline, so long as they were not combined with the problems of class and longeivity, also proved easier to reduce than the effects of organizational placement and the deeply embedded disadvantages of class.

Table I: Power, participation and satisfaction by individual characteristics[a]

Power and Participation	Length of time in organization	Proximity to central building	Age	Class (working class parents)	Race	Sex
Speaking at meetings	.261*	.226	.202	.374**	-.015	.111
Attending meetings	.277*	.264*	.285*	.458**	.040	.187
Ranked high in "power" by other staff	.280*	.093	.220	.259	.166	.055
Chosen as influential by other staff	.234	-.189	.166	.145	.004	.028
Feelings of Efficacy and Satisfaction						
Reports self as high in "power"	.287*	.251	.253	.359*	.110	.205
Reports satisfaction with decisions	-.173	.205	.173	.305*	.071	.251

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[a] These calculations are Pearson product-moment correlation coefficients based upon forty-one cases, with some variation for non-response. For example, if every man spoke once at Community Days but no women spoke, this perfect correlation would be represented by +1.000. If men and women were exactly equally likely to speak, this absence of any correlation would be represented by .000. A strong correlation, like that between education and income in the United States, would be about 400. As most of these variables have non-linear relationships, the correlations should be understood as approximations. Since this is a total population, and is not necessarily representative of similar organizations, tests of statistical significance are in some respects inappropriate, but I have nevertheless used asterisks to indicate conditions which would be significant if this were a random sample. *indicates $p= <.05$(which means there are less than five chances in one hundred that this distribution of responses is random); **indicates $P <.01$ (less than one chance in a hundred); ***indicates $p= <.001$ (less than one chance in one thousand). No asterisk indicates that in a sample this size, the probability of a relationship like the one depicted occurring by chance is greater than five in one hundred.

"Speaking at meetings" combines a questionnaire report of how frequently one speaks at meetings with observed measures of speaking in the major representative committee and at Community Days. "Attending meetings" combines one questionnaire report of attendance with observed measures of attendance in six different forms over six months. "Ranking high in 'power'" derives from an exercise administered at the end of the interview. "Chosen as influential" derives from responses to a question on the questionnaire asking, "If you wanted to discuss Helpline issues with someone, who are two people whose judgement you would most respect?" "Reports self as high in power" combines one's self-ranking on the power exercise with two questionnaire items reporting amount of "say" in decisions at Helpline. "Reports satisfaction with decisions" combines four questionnaire items reporting various forms of satisfaction.

Yet even in this radical workplace, which was going to some length to eradicate oppressive stereotypes and structures, the women faced subtle disadvantages in communicating persuasively their ideas on the future direction of the organization. When the members of the organization ranked themselves and the rest of the staff according to their "power" in the central organization, women received rankings equal to those of the men. Women were also as likely as men to be chosen in response to the question, "If you wanted to discuss Helpline issues with someone, who are two people whose judgement you would most respect?" (see second two items under "Power" and "Participation," Table I). In terms of influence networks, and of being able either to get things done or to get other people to do what they would otherwise not have done (two common definitions of power), women were therefore perceived as equal to the men.

My own observations of decision making at Helpline also suggest that the women may have had as much "power" as the men. They seemed, by and large, as able as the men to get what they wanted and to get the others in the organization to do things they would otherwise not have done. The women worked hard, had good ideas, seemed to command considerable respect.

Yet if they exercised equal power, they did so, with one major exception, behind the scenes. They did not take either of the two major leadership positions at Helpline, that of the Coordinator and Treasurer. Only one woman had ever become a fundraiser. In the six decisions I studied closely, women took major initiating roles in only one, and that one (eliminating the job of "office manager" or secretary) was explicitly a women's issue. Women attended fewer meetings and spoke less at meetings than did the men (see first two items under "Participation and Power," Table I).

Why did most of the women at Helpline opt for invisible power? My data suggest that the women had lower verbal self-confidence, a weaker career orientation, greater interest in curing people than in administering an organization, and no model for leadership other than that of the "pushy bitch."

On a checklist of traits, the women of Helpline were significantly more likely than the men to report that "articulate people intimidate me," ($N=32$; $p= <.01$) and less likely to report "I express myself well in words." ($N=31$; $p=<.05$). They were somewhat less likely than the men to report that "people seem to respect my opinion about things," and more likely to report that "I don't like to 'operate.'" These responses were associated at Helpline with the tendency to take on leadership positions. Except for the strong difference in verbal self-confidence, however, the differences should not be taken too seriously. Although the men tended to have more positive attitudes towards the exercise of power, the differences were not large. Women were more likely than men to report, "I like taking responsibility," and there was no difference between men and women reporting, "I enjoy power,"[2] It was the level of verbal self-confidence that most distinguished men from women. As one woman put it, "I often feel that I've got to hear everything before I can say something, because I feel insecure about saying things. I am especially insecure if it's mostly males talking."

Women at Helpline also seemed less likely than the men to think of their work as part of a career. Only 15% of the women intended to stay at Helpline more than a year, compared to 53% of the men. Even among these who intended to stay the same length of time, "It's just a whole different headset the men are into, like it's their career." In the American economy, interrupted careers explain almost 60% of the difference between men's and women's wages.[3] At Helpline, an "interruptable" career orientation may help explain the subtle differences in power and participation between men and women.

Thirdly, the product at Helpline is counselling. Most of the staff joined Helpline for the direct satisfaction of doing counselling. No one was particularly interested in administration, including the coordinator-director, whose full-time job was administration, and who considered it "shitwork." The men may however, have been more likely to "get off on" the power and status of administration. As one woman said of the coordinator-director, whom she liked,

> "Like he realizes that the fact that he's director has nothing to do with what he does as a job and enjoys doing. It's the thing of 'I'm the director; look at me!' And it's just very strange to me. I wouldn't do that for all the world! But somehow to men there's a reward associated with it. You do the shitwork, but the title is a good enough reward!"

If the men were more gratified by status rewards or the women by nuturant ones, this would help explain the men's slightly greater likelihood of holding administrative positions.

When I interviewed the women who did take leadership roles in Helpline, however, another potential barrier emerged. Everyone in this participatory democracy had trouble conceiving what truly democratic leadership would look like. For the women, this problem was compounded. It was hard for women to visualize any female leadership that was not "bitchy." One woman who did not usually take on leadership but worked hard to push a controversial innovation, remembered, "I was afraid that I was coming on bitchy...I feel that if I'm at all bitchy, they are going to use it against me." Another avoided bringing up issues because "I get all hostile and bitchy." A third woman refused after a while to go to any of the large Helpline meetings. She felt that even in the small meetings of her group, she was "put in a role where I would voice the bitchiness and anger everyone had...They put me in this role--I took it myself, too--of house bitch, so when there's something disagreeable to say, they let me say it."

Eight years before I interviewed people at Helpline, a survey of 1,000 male executives and 100 female executives reported that 91% of the men and 85% of the women believed that men would feel uncomfortable working for a woman.[4] At Helpline, no one worked "for" anyone else, but there were acknowledged differences in power. Even in 1973, in this egalitarian organization, holding a position of leadership seemed more difficult for a woman than for a man.

Kaye, generally acknowledged to be the most powerful woman at Helpline, exemplified some of the tensions that any person with more than equal power would feel in an egalitarian organization. In her case, the tensions were exascerbated by being a woman and having to take the role of "exceptional woman" in a man's world. Among the five staff members rated most powerful out of the total of forty-one staff, Kaye was the only woman. She was energetic, intelligent, feisty, and decisive. As "vice-coordinator" of Helpline, she kept a file of the minutes, and as one of her (male) enemies put it, "she has an encyclopedic memory for conversations and commitments that have been made." She liked to have things put in writing, pushed to have the minutes written up on time, and fought the fuzzy-edged decisions that tend to emerge in a consensual process. She had been for a long time a strong advocate of formal evaluations.

Kaye had no trouble speaking up or getting angry. At the average meeting at Helpline's major representative committee she spoke twice as much as any other woman and almost half again as much as any man. Her participation alone raised the average number of times women spoke in those meetings from 8.5 to 11.3, more than equal to the male average of 11.1. She also provided eight of the nine times women got angry in the meetings, thereby creating an average score of anger among the women equal to that of the men. Without her activity, the women's scores on the public activities of attending meetings and speaking would have been even lower than they were (see Table 11).

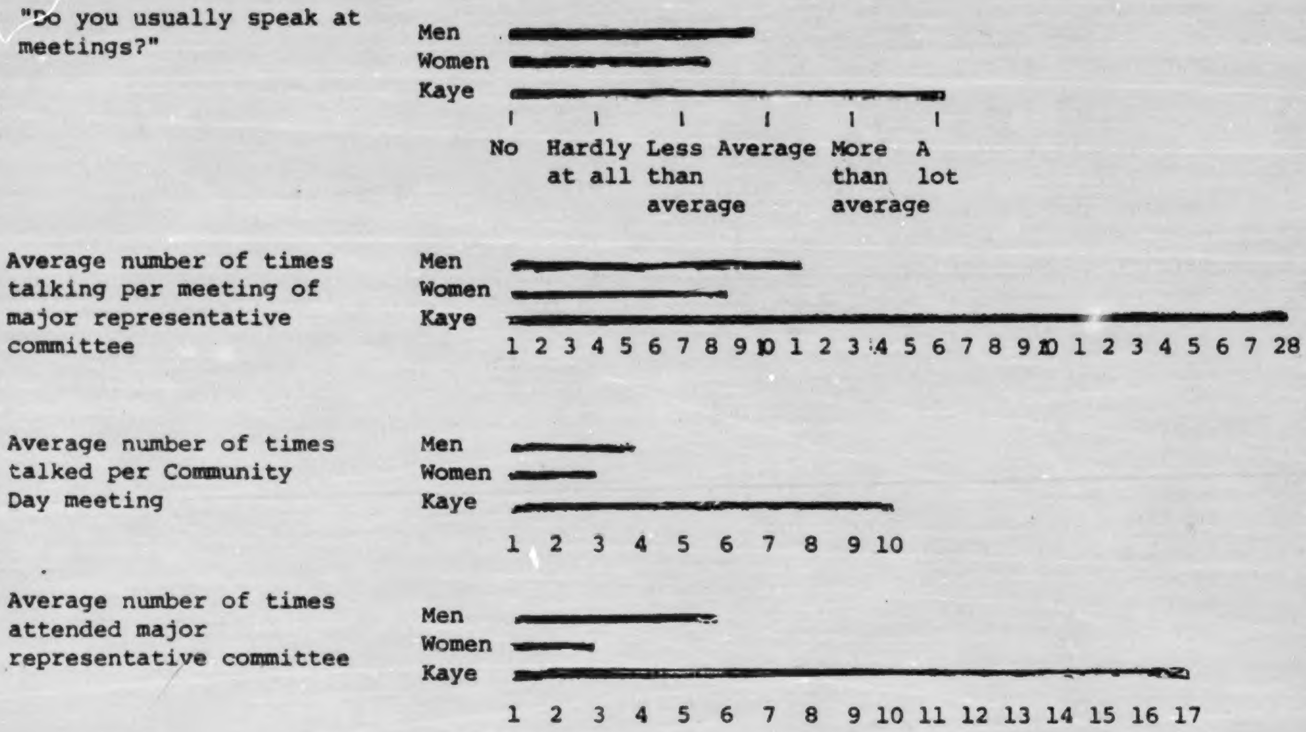
When I asked Kaye her feelings about conflict, she said, "Conflict doesn't bother me, frankly. The model set up for me does very well under conflict. I come out well enough personally to be very selfish about it--if it's really there, I prefer to deal with it honestly." She was right. In one of the best meetings I witnessed at Helpline, she chaired the meeting brilliantly. She kept people from interrupting. When it got to be late and the discussion still raged, she quieted anxieties about the time by commenting, "People haven't been repeating themselves. As chair, I'll try to keep an eye on that." Toward the meeting's end she called out, "TIME! We have five more minutes. Is there anybody who hasn't said anything at all?" and she made sure subsequently that each quiet person did have a chance to speak. Finally, when everyone had burst for a moment into emotional pandemonium, Kaye quieted them, then exulted out loud, "I love being chairperson at meetings like this!"

Kaye used her anger to chivvy her colleagues into making their policies explicit and remembering what decisions had been made. One day, for instance, I overheard her in the corridor dressing down two colleagues in her service group:

> Woman: I didn't realize...(unintelligible)
>
> Kaye: ...and I'm upset about it. And if you want that policy changed, you bring it up!
>
> Woman: Maybe it's time to clarify it (the policy)?
>
> Man (interjecting): We've been gradually clarifying it...
>
> Kaye: (to the man): Speak for yourself! I've always been clear about what I was doing...Read the damn training manual!

Shortly afterward, the woman, who had an appointment with me for an interview, postponed our meeting, saying "I'd better not do the interview now, I'm pretty shaken up."

Table II: Men, Women and the Exceptional Woman



In one important meeting of the major representative committee, Kaye insisted, against considerable resistance, on written as well as oral reports. After much back and forth, she blew up: "It's not reasonable to present a comprehensive picture in ten minutes! There are seven discrete things (reports) and we're talking about spending one or two minutes on each of them! I'm tired of making decisions on the basis of how mellow somebody's rap sounds!" The group agreed to written reports. The next week she had to repeat the act. A staff member who had not been at the previous meeting brought up the issue again, arguing that "Position papers don't get read." Kaye snapped back: "If people don't read it, that's their lookout!" The response, "I don't want an organization based on position papers," made her hit the roof: "That's not what I said, and I resent that. It's something that meant alot to me last week, and I'll repeat it!" Consensus was reached again to have written reports.

These bludgeoning tactics, though relatively successful in the short run, took their internal toll. A few minutes after the first meeting, I passed Kaye on the stairs, looking exhausted, depressed, and, I thought, on the verge of tears. To my expression of concern, she shook her head: "I'm afraid I did it again--really laid my rap on them. (Pause)--But I really believe that things should be written out!" Later, in the interview, I asked Kaye about some of the highs and lows she'd experienced working at Helpline. She had told me about some of the highs, and when I asked, "What about downs?" she responded,

> Big downs? Yeah. Stuff like--do you remember the meeting before the Community Day, when people said they didn't want to do written stuff? And I got mad and I hollered at people and lectured them? That was a down.
>
> I did that because I felt that I had to do it. That it was an important thing and it wasn't going to be done unless I said that it needed to be done. And that if I said it needed to be done and it still didn't get done, I'd have to lecture and be "mommy" and scold people and make them feel guilty so they would do it. It was a downer. It was a down that people just were unwilling to put in a little bit of work that could really make something like that (Community Day) a lot more positive.

J: How did you feel?

K: I was angry, I was frustrated, and I was pissed. I was pissed at myself for buying into that role, I don't like it. I was very, very angry.

J: Do you ever feel physically nervous or sick after meetings?

K: Sometimes I get a headache after meetings. (laugh). Yeah, I had a headache after that meeting. I work myself up, and my adrenalin comes pounding out, and I get it all out.

> And I get people to do things. I'm very effective as a hatchet woman. I mean, when I want people to do things, they goddamn well do them! And I know that! Big Power! That's the part that's an ego trip.
>
> The other part is the part that makes me sad, because people don't do things that it makes a lot of sense for them to do.
>
> It makes me sad that I get off on being that sort of person--because I don't like being that kind of person. That makes me very, very angry.

Much of Kaye's ambivalence about getting people to do things stems from her human sensitivity to what that position does to others and what it does to her. When I asked, at the beginning of the interview, why she had come to Helpline, she mentioned that "the verbiage of it being an egalitarian structure seemed very appealing, particularly since I would be a new person, and in the structured situation near the bottom." Fairly soon afterwards, I returned to the subject:

> J: Did you know at the time (when you were looking for jobs) about equal salaries?
>
> K: Oh yeah. (J: That was a plus?) Yeah. I could have made twice as much, easily.
>
> J: Why was it important to you?--You said it felt crummy to be at the bottom--
>
> K: Yeah, it's also crummy to be at the top! For me because I'm a fairly aggressive person, and I think that sets me up in a situation where it allows me to be too many things that I don't like being--if I'm at the top. And I'm a strong enough person so that being at the bottom is just chafing.
>
> I think that being at a place in a dominance structure is not for me a healthy thing. I'd rather be able to be strong when I feel like being strong, and be able to do leadership because I feel good about doing it, and still be able to trust that other people will be able to do it too.

Subtly, however, the question of what was appropriate for a woman mixed itself in with the simpler dislike of inequality in power.

> I'm pretty sure that a lot of men (at Helpline) are not getting various societal power needs met by the job that they might traditionally be able to expect, because in most working situations men have more status than women. The men are usually making more money and usually have more underlings. That doesn't happen here.

> There's another thing--(our group) has three very strong women in it--Linda, Amy and I. And it's kind of like the three of us are very, very together, and agree and talk a lot, and know how the others think and can therefore be super-supportive. I mean Amy is a very, very tough woman. And she's something plenty heavy to cross when she's angry! (laugh) - I'm very serious about it.

She spoke of a women's group that two other women started at Helpline. She has only a peripheral relation to the group, but concluded,

> I think that it changed things here a lot. I think that Helpline has a very sexist history.
>
> I guess people don't give me that shit because I'll bite their goddamn heads off if they do! (laugh) I think they know that, and I've bitten people's heads off about that.
>
> Anyway, I'm stronger than most of the men here. And I know it. And they know it. (laugh) I'm more forceful, I'm more definitive, I push more if I want something; I'm more able than many of the men here to play a leadership role; I do it more effectively, with more ease. And I know a lot more than a lot of the men here. (laugh) I'm smarter and better trained.
>
> J: How come you've never thought of being director?
>
> K: I have thought of it.
>
> J: Why did you (not do it)?
>
> K: It's an administrative job. I get some of my rocks off, as they say from pushing that whole list of things that I just talked about, that are strong--but it's not enough. And in the end it's very frustrating.
>
> I mean, it gives me pleasure, and makes me feel tough. It's nice, it fills a lot of my fantasy needs, but it doesn't leave the kind of pleasure and satisfaction--it doesn't give me a real up; it gives me a mean up, frankly--"Aaah, I got that bastard down"--rather than saying, "Wow. I did something, and it's cool, and I really dig it."

The "mean up" that can accompany an exercise of power worried a number of people at Helpline. But it particularly worried Kaye that she "gets off on being that sort of person," and that she became "too many things that I don't like being," because she had no model of what it might be like to be woman, to exercise power, and not to be a bitch. One of Kaye's favorite locutions in describing how she got things done was to say that she made "a lot of noise." About her crusade for evaluations, she said, "They know that Kaye will make a lot of noise and bitch if we try to make them a cursory thing." While doing the power ranking exercise, she placed herself quite close to the top center, commenting, "I think I have lots of power. Isn't that terrible? I make a lot of noise." (Later, I asked what she had meant by, "Isn't that terrible." She replied, "Well, I was joking.")

Noise is contentless. The phrase "making a lot of noise" implies coercion, not rational persuasion. It is, moreover, coercion on a primitive scale; the screams of a baby simply irritate the adult human beings within hearing until they supply what the baby wants. When Kaye thought of herself and the other woman at Helpline, she used the words "making noise," but when she thought of men in the same context, she used the word "influence." In one question, for example, I asked which staff members at Helpline had been particularly influential in the few decisions I was studying closely. Kaye mentioned only four people by name, two of them women, two men. The interchange went like this:

> J: (Who do you think was most influential) in the office manager decision:
>
> K: Debby and Donna made a lot of noise. That's why it happened.
>
> J: In the Hanscom Field decision?
>
> K: Len and Bruce had the greatest influence I think.

Kaye used the phrase, "making a lot of noise" six times throughout the interview. Five of these described the exercise of power by women. The sixth described a man she did not trust, whom she felt "has no scruples (and) operates primarily out of self-interest."

In short, Kaye, the one woman at Helpline powerful enough to raise the women's power and participation to almost equal those of the men, was deeply ambivalent both about what exercising power did to her and those around her, and about the methods she perceived herself and other women using to get things done. Even she did not seem to have escaped the common social definition of a woman's role. As another woman at Helpline told me:

> I know that Kaye, for example, when they were decided about coordinator, said that she didn't want to do it because she didn't think that a woman would be as good, relating to the outside world about Helpline, as a man would be. She thought that practically it made more sense to have a man there. The world would respect that more. So I don't think she feels it's her place, so to speak.

Conclusion

Helpline, a workplace dedicated to democratic participation, revealed few strong differences in participation between men and women. Men, however, occupied the public leadership roles. The one woman who took a major position of leadership felt profoundly ambivalent about what that role would do to her and to others around her. She thought of public responsibility and the gratifications it provided as essentially male--"getting your rocks off." Perhaps in response, she infantilized her own leadership actions, reducing them in her mind to making "noise," An atypical organization like this which tries hard to lower external barriers to equal participation brings internal problems of self-concept into higher relief. In Helpline, the women actually spoke in meetings only a little less frequently than the men, but they were significantly less confident about their speaking ability. The women attended almost as many meetings as the men, and others rated them as having essentially equal power, but they were noticeably less likely than the men to consider themselves powerful.

Kohlberg argues that the difficulty in shaking off sexual stereotypes derives from early embedding gender into the very concept of self. Before children know what gender means, before they can identify a doll or a parent as male or female, those children have learned their own gender. They first incorporate their gender into their definition of themselves, then proceed energetically and positively to try to find out what, in the real world, that gender "means."

Problems in eradicating the resulting "discoveries" therefore derive from their being the product not of simple stimulus-response training, but of a driving search for self.[5] Whatever the reason for the strength of these stereotypes, my research indicates that even among young, "liberated" women in an earnestly egalitarian institution, a non-powerful self-concept persisted in the fact of both open access to power and almost equal participation and power. The one woman who took a visible leadership role and could not ignore the obvious fact of her greater power defused its threat by belittling her actions as "noise" and finding for herself a traditional female role, the bitch.

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FOOTNOTES

[1] The name "Helpline" and the personal names in this essay are fictitious. My observations of this organization form part of a larger study of egalitarian decision-making, including data from a New England town meeting and a Women's Center organized on anarcho-feminist principles.

In this case I attended meetings for six months in 1973, taking notes on the extent as well as the content of each member's participation, interviewed forty of the forty-one members in a generally unstructured format for an hour or more, and received from every member responses to a written questionnaire. Toward the end of each interview, I asked the staff member I was interviewing to participate in a power-ranking exercise, from which the measures "Ranked high in 'power' by other staff" and "Reports self as high in 'power' " (Table I) are drawn.

[2] Table III reports the means of men and women at Helpline to questions in which the possible responses ranged from "Never true" (1) to "Almost always true" (5).

Table III: Reported Personality Attributes by Sex

Correlation with ranked "power" a/		Women (N=12) b/	Men (N=20)	Diff. c/	Prob.
-.345	Articulate people intimidate me	2.0	.8	1.2	<.01
.395*	I express myself well in words	2.2	2.9	.7	<.05
.352*	People seem to respect my opinion about things	2.7	3.2	.5	-
-.434	I don't like to 'operate'	2.2	1.7	.5	-
.248	I have strong political opinions	2.3	2.7	.4	-
.478*	I like competition	1.9	2.2	.3	-
.291	I'm good at making decisions quickly	2.4	2.7	.3	-
.405*	I enjoy planning things and taking charge	2.6	2.8	.2	-
-.571***	I hate to tell others what to do	2.3	2.1	.2	-
-.237	I am easily downed in an argument	1.5	1.3	.2	-
.216	I can usually find a way of giving criticism without upsetting a person	2.5	2.6	.1	-

An atypical organization like this which tries hard to lower external barriers to equal participation brings internal problems of self-concept into higher relief. In Helpline, the women actually spoke in meetings only a little less frequently than the men, but they were significantly less confident about their speaking ability. The women attended almost as many meetings as the men, and others rated them as having essentially equal power, but they were noticeably less likely than the men to consider themselves powerful.

Kohlberg argues that the difficulty in shaking off sexual stereotypes derives from early embedding gender into the very concept of self. Before children know what gender means, before they can identify a doll or a parent as male or female, those children have learned their own gender. They first incorporate their gender into their definition of themselves, then proceed energetically and positively to try to find out what, in the real world, that gender "means."

Problems in eradicating the resulting "discoveries" therefore derive from their being the product not of simple stimulus-response training, but of a driving search for self.[5] Whatever the reason for the strength of these stereotypes, my research indicates that even among young, "liberated" women in an earnestly egalitarian institution, a non-powerful self-concept persisted in the fact of both open access to power and almost equal participation and power. The one woman who took a visible leadership role and could not ignore the obvious fact of her greater power defused its threat by belittling her actions as "noise" and finding for herself a traditional female role, the bitch.

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FOOTNOTES

[1] The name "Helpline" and the personal names in this essay are fictitious. My observations of this organization form part of a larger study of egalitarian decision-making, including data from a New England town meeting and a Women's Center organized on anarcho-feminist principles.

In this case I attended meetings for six months in 1973, taking notes on the extent as well as the content of each member's participation, interviewed forty of the forty-one members in a generally unstructured format for an hour or more, and received from every member responses to a written questionnaire. Toward the end of each interview, I asked the staff member I was interviewing to participate in a power-ranking exercise, from which the measures "Ranked high in 'power' by other staff" and "Reports self as high in 'power' " (Table I) are drawn.

[2] Table III reports the means of men and women at Helpline to questions in which the possible responses ranged from "Never true" (1) to "Almost always true" (5).

Table III: Reported Personality Attributes by Sex

Correlation with ranked "power" a/		Women (N=12) b/	Men (N=20)	Diff. c/	Prob.
-.345	Articulate people intimidate me	2.0	.8	1.2	<.01
.395*	I express myself well in words	2.2	2.9	.7	<.05
.352*	People seem to respect my opinion about things	2.7	3.2	.5	-
-.434	I don't like to 'operate'	2.2	1.7	.5	-
.248	I have strong political opinions	2.3	2.7	.4	-
.478*	I like competition	1.9	2.2	.3	-
.291	I'm good at making decisions quickly	2.4	2.7	.3	-
.405*	I enjoy planning things and taking charge	2.6	2.8	.2	-
-.571***	I hate to tell others what to do	2.3	2.1	.2	-
-.237	I am easily downed in an argument	1.5	1.3	.2	-
.216	I can usually find a way of giving criticism without upsetting a person	2.5	2.6	.1	-

TABLE III (cont.)

Correlation with ranked "power" a/		Women (N=12) b/	Men (N=20)	Diff. c/	Prob.
-.284	Meetings bore me	2.3	2.2	.1	-
.599***	I like taking responsibility	3.0	2.9	-.1	-
.383*	I enjoy power	2.6	2.6	0	-

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a/ Pearson product-moment correlation of reported personality attribute with average "power" rank at Helpline. *p = < .05; **p = < .01; ***p = < .001. Correlations below .200 not reported.

b/ Thirty-two of the forty-one staff members answered this optional portion of the questionnaire.

c/ Difference between male and female scores is reported positively both when males score higher and trait is positively correlated with power, and when males score lower and trait is negatively correlated with power.

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[3] Suter, L.E. and H.P. Miller, "Income Differences Between Men and Career Women." American Journal of Sociology, 78, 1973, pp. 962-974.

[4] Bowman, G.W., N.B. Worthy and S.A. Greyser, "Are Women Executives People?" Harvard Business Review, 43, 1965, pp. 14-30; cited by Kanter, Rosabeth, "Women and the Structure of Organizations." In Millman, Marcia and R.M. Kanter (eds.), Another Voice. Garden City, New Jersey: Anchor Press/Doubleday, 1975, p. 60.

[5] Kohlberg, Lawrence and Edward Zigler, "The Impact of Cognitive Maturity on the Development of Sex-Role Attitudes in the Years 4 to 8." Genetic Psychology Monographs, 75, 1967, pp. 100-105; excerpted in Lee, Patrick C. and Robert S. Stewart, Sex Differences. New York: Urizen Books, 1976.

IX.

INNOVATIVE PROGRAMS

To facilitate women's movement into positions of leadership and authority, new approaches to old problems have been instigated in a variety of fields.

Shapiro reports on issues involved in establishing a reduced-schedule residency training program at Harvard Medical School. Gorton describes the creative leadership training program for graduate nursing students developed by Claus and Bailey at the University of California, San Francisco.

REDUCED-SCHEDULE GRADUATE MEDICAL EDUCATION:
A STATUS REPORT

Eileen Shapiro

and

Shirley G. Driscoll

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REDUCED-SCHEDULE GRADUATE MEDICAL EDUCATION: A STATUS REPORT

Eileen Shapiro and Shirley G. Driscoll

Among recent trends within graduate medical education in the United States is the increasing interest in reduced-schedule or part-time training. Reduced-schedule residencies* permit physicians to do part or all of their postgraduate training on a "part-time" basis. In comparison to the 80-120 hours per week that many house officers in primary care specialties commonly spend on active duty or on call, reduced-schedule residencies usually require 35-60 hours weekly.

Reduced-schedule residencies, especially those conducted on a shared schedule basis, constitute an exciting innovation in medical education which allows more flexible training schedules. Young physicians may thus continue medical training while meeting other commitments or concerns--for example, to research, to personal and/or family needs, or to personally valued avocations. Some students see reduced-schedule residencies as means of combining medical training with other clinical interests (working in a community health center, for example); others describe such training as a way of "preserving their humanness" while gaining expertise in their chosen specialty. Beyond their importance for the part-time residents themselves, reduced-schedule residency programs can provide stimulus to re-evaluate optimal scheduling of on-duty hours and to consider other nontraditional work schedules in medical training and practice.

This paper focuses primarily on the shared type of reduced-schedule graduate medical education, with an emphasis on training in the primary care specialties. It is divided into three sections. The first describes the current status of reduced-schedule residencies, including the role of the Harvard Reduced-Schedule Residency Project (HRSRP). A second section considers the users of reduced-schedule residencies--past, current, and future. The history of efforts to establish part-time residency training is reviewed and current issues relevant to the future of such training, including the provisions of Section 709 of the Health Professions Educational Assistance Act of 1976 (HPEAA) regarding "shared schedule physician training positions," are considered. The final section discusses reduced-schedule residencies in the larger context of graduate medical education. The information, ideas, and issues presented are intended as stimulus to future discussion, planning, and implementation.

Reduced-Schedule Residencies: Current Status

The Harvard Reduced-Schedule Residency Project

The HRSRP, directed by the authors, has three major foci: 1) coordination of efforts to establish reduced-schedule training; 2) integration of such training into the larger framework of American graduate medical education; and 3) evaluation of reduced-schedule training. Supported by the Rockefeller Family Fund, the Project is the only national effort working toward these objectives.

Establishment of opportunities for reduced-schedule training on a national basis has been successfully encouraged. The HRSRP has published several editions of the Directory of Institutions Offering Reduced-Schedule Training.[1] The most recent edition (April 1976) lists 500 residency programs at 200 hospitals, based on a survey of 300 of the 1700 or so hospitals that have LCGME-accredited residency programs. During academic year 1976-77, the HRSRP, in collaboration with the Association of American Medical Colleges (AAMC), updated and expanded the previous survey to include all hospitals with accredited residency programs. The resulting directory, available in August 1977, will constitute the most complete source of information on residency programs with option(s) for reduced-schedule training.

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*We use the word "residency" to include both internship and residency.

With the work toward establishment of reduced-schedule training well under way, the attention of the HRSRP now focuses on integrating such training into the larger framework of American graduate medical education. Since the only accurate listings of institutions offering reduced-schedule graduate medical education are those compiled and distributed by the HRSRP, and since arrangements for those positions are made on an ad hoc basis, the number of individuals currently able to arrange part-time training is extremely limited. Efforts to integrate reduced-schedule training as established positions in accredited residency programs, listed in the LCGME's Directory of Accredited Residencies and matched by the National Intern and Residency Matching Program (NIRMP), face strong opposition from those who believe that such training should be open only to individuals who would otherwise be unable to pursue graduate medical education. Thus the question of for whom reduced-schedule training should be available becomes of prime importance.

Evaluation of reduced-schedule training as an alternative to traditional programs involves complex issues. The HRSRP has attempted to evaluate the design of reduced-schedule residencies with the goal of developing and refining models for high quality part-time training. The important work of evaluating the training received by reduced-schedule residents in comparison with their full-time colleagues has not yet begun.

Structure of Reduced-Schedule Residencies

Reduced-schedule residencies can be structured in two ways: either as additional part-time positions with a reduced time commitment (e.g. one house officer working two-thirds time) or as shared schedule positions (e.g. two house officers sharing one residency slot, each working two-thirds time).

Reduced-schedule residencies, in order to be successful, must be scheduled so that continuity of patient care (or of related services) is maintained, house officers benefit from the educational activities of the program, and costs are minimally increased for the hospital. In some specialties, such as Dermatology, Pathology, Anaesthesiology and Radiology, the conventional model of an additional part-time position with a reduced-time commitment may meet these requirements; for primary care specialties, however, part-time training based on a shared schedule model better fulfills the requirements for high quality training. The latter model is also appropriate for Surgery and the surgical subspecialties.

In general format, the HRSRP describes shared schedule residency positions as follows: two physicians share one house-officer position, each working two-thirds to three-quarters time, and each receiving at least half pay, full benefits, and credit equivalent to the time spent. This general format contains a substantial amount of overlap time for the two "halves" of a shared position. Overlap time is included specifically to facilitate continuity of patient care between the two residents and to allow both to participate in the major educational activities of the service--as to attend rounds and conferences. The general model was also developed with hospital economics in mind: hence the guidelines of at least half pay and full benefits for shared schedule residents. Thus, while the cost to hospitals is increased by an additional benefit package, the services rendered by the two halves is greater than 100% of a regular full-time position, enhancing the economic feasibility of the model. Finally, acknowledging that previous part-time residents who were half-time in name and in credit received, worked, in fact, two-thirds to three-quarters time, equitable credit toward certification should be in proportion to the amount of training actually engaged in by the residents.

Under the general format for shared residencies described, we present three specific alternatives and a fourth "hybrid" model. They are:[2]

1. The interdigitated continuing model (ICM). In this model, two residents are paired in one training slot, both working approximately two-thirds to three-quarters time throughout the year. A prototype for this kind of schedule might be: both residents are present in the morning, thus both are able to participate in rounds, meetings, and conferences, and any other teaching activities that occur in the morning. The afternoon and evening schedule is split between the two residents, with both present when needed. Night and weekend call is split on an alternating schedule.

2. Alternating full-time blocks. This model has two variants. In the first, two house officers share one training slot, with one working full-time while the other if "off" for a block of time; for example: one month on, one month off, or six months on, six months off. Under this variant, the "off" halves might continue to attend to their ambulatory patients, thus providing continuity of care to their outpatients and meeting the two-thirds to three-quarters time requirement. Alternately, it may be more appropriate in a given program for both halves to be on duty together for several months and then to alternate in full-time blocks for the remainder of the year. In the second variant, two house officers work as a pair, sharing one training slot, each working alternate days of the week while sharing night and weekend call, with both halves scheduled to be on duty simultaneously as necessary. Actual scheduling for both of these variants can be modified or adjusted to meet the particular needs of individual programs.

3. "Night float." With the "night float" system, one or several residents is on night duty (and sometimes weekend duty as well), while the rest of the resident(s) work during the days on a rotating schedule. Night float can be arranged so that both the "night" resident(s) and "day" resident(s) participate in morning report, rounds, and/or conferences.

A typical night float schedule might involve coming on at 6 p.m., making rounds on all relevant wards to get problem lists and seeing problem patients with the day resident(s). In the cases of very sick patients who require close attention, the appropriate day resident stays on until the situation has stabilized. The night float is off duty at 7 a.m., when the day residents resume responsibility. After reporting on the patients and perhaps attending morning report and/or rounds, the night float leaves the hospital between 8 and 9 a.m.*

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*This description is based on the night float system used in the Internal Medicine program at Strong Memorial Hospital during the early sixties, as described by Carol C. Nadelson, M.D., a former house officer in the program.

4. Variably scheduled. For some programs, a combination of the models described above may be more useful than any one used singly. For example, in those services involving both inpatient and ambulatory care, it may be desirable to devise a shared schedule for the time spent on inpatient rotations (using, for example, the ICM model or the alternating full-time blocks model), while using a traditional part-time schedule for ambulatory care rotations (e.g. straight two-thirds time).

Prototype programs exist of the first three models described. As examples, full-time residents in the Family Practice programs at Montefiore Hospital and Medical Center (New York City), the University of Rochester-Highland Hospital or Rochester and the University of Washington Affiliated Hospitals (Seattle) work in pairs, in a manner similar to that described for the ICM model. In these programs, however, both house officers are on duty during the afternoon, one at the hospital and the other in a family practice clinic, on an alternating basis. Other programs have been scheduled to permit house officers to combine clinical training with research by alternating full-time blocks of clinical work and research. Such a program currently operates in Internal Medicine at the Peter Bent Brigham Hospital in Boston. The night float system has also been used by various programs, among them the Internal Medicine program at Strong Memorial Hospital (University of Rochester).

Reduced-Schedule Residencies: For Whom and How Many?

Part-time residencies were initially intended for those physicians unable to pursue graduate medical education on a full-time basis; i.e. women with children or other physicians who, usually for reasons of ill health, could undertake only part-time training. Most of the part-time residencies were arranged on an *ad hoc* basis, principally for women and principally in Psychiatry. Efforts to establish part-time programs were, for the most part, on a small scale, local rather than national, and essentially restricted in vision to mothers in medicine.

In 1971 at Harvard Medical School, a group of first year students began to meet with a group of faculty to discuss the feasibility of establishing part-time residency positions at Harvard teaching hospitals.* Their efforts[4] expanded under the auspices of the Joint Committee on the Status of Women (1974-76) and the HRSRP (1976 to present). As the work on reduced-schedule residencies has progressed, the question of for whom such positions should be available has received considerable attention.

By 1974, part-time positions in some programs were still explicitly limited to women, even though such restrictions were by then and continue to be illegal: whether considered as student positions or employment positions, all forms of residency training must be open to men and women, regardless of marital or parental status.[6] Even so, the most recent Directory of Accredited Residencies[7] includes this statement: "As in previous years, hospitals were asked whether they would be willing to offer part-time graduate training programs to men and women on specific request if satisfactory programs could be organized. The replies indicated that 89 hospitals would offer part-time internships to women, and 38 would offer part-time internships to men."

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*Efforts from within Harvard University to facilitate part-time medical training predate the formation of this small group. Chief among these efforts were those undertaken by the Radcliffe Institute. During 1960-71, the Institute supported fifty-three women physicians, ten as Radcliffe Institute Scholars in the Program for Independent Study and 43 in the Fellowship Program for Women in Medicine and Medical Sciences, underwritten by funds from the Josiah Macy, Jr. Foundation. Most of these women physicians were married with young children, and the financial awards provided by the Institute were intended to make possible or facilitate arrangements for part-time training.[3]

In addition to the legal imperative, the position of the HRSRP is that reduced-schedule training must be available to all physicians who wish to pursue their education at a less pressured pace or who wish to combine their training with other concerns or commitment: to a particular research interest, to personal and/or family needs, to a personally valued avocation, or to other medical interests.

Expanding the pool of potential users of reduced-schedule training, from those for whom it is a necessity to include those who wish it for other reasons, carries major implications for graduate medical education in this country, as the following discussion suggests.

At present, the "Essentials of Approved Residencies," promulgated by the LCGME, indicates that part-time programs are to be made available in those "particular circumstances under which physicians can undertake graduate medical education only on a part-time basis,"[8] (emphasis added). The most recent data available from the A.M.A. indicate that there were a total of 118 part-time residents as of 1 September 1974, 76 women and 42 men. Of these 118, slightly more than half (64) were in Psychiatry or Child Psychiatry.

It seems clear that as long as reduced-schedule residencies are arranged on an *ad hoc* basis and permitted only for reasons currently specified in the "Essentials of Approved Residencies," only those physicians who are determined, energetic, and in desperate need will take advantage of them. In that case, we can predict that reduced-schedule residents will comprise only a small proportion of the total number of house officers, probably 100-200 per year.

However, compliance with Section 709 of the HPEAA[9], which mandates shared schedule positions in primary care training programs, will significantly alter this situation. Section 709 states that"

"(a) Any entity which--

"(1) maintains a medical residency training program in family practice, general internal medicine, general pediatrics, or general obstetrics and gynecology, and

"(2) receives any Federal assistance, shall establish or restructure and maintain, to the maximum extent feasible, a reasonble number of physician training positions in such program as shared schedule positions.

"(b) The secretary shall report to Congress not later than January 1, 1979 on entities' compliance with subsection (a) and shall include in such report recommendations for legislation to ensure compliance with such subsection.

"(c) For purposes of subsection (a), the term 'shared schedule position' means a physician training position in a medical residency training program which is shared by two individuals and in which each individual--

"(1) engages in at least two-thirds but not more than three-fourths of the total training prescribed for such position,

"(2) receives for each year in such position an amount of credit for certification in the medical specialty for which the position provides training which is equal to the amount of training engaged in in such year,

"(3) receives at least one-half of the salary for such position, and

"(4) receives all applicable employee benefits."

Despite the imprecision regarding the number of such positions to be established--the law specifies "to the maximum extent feasible, a reasonable number"--the intent clearly is to make shared schedule residencies more readily available than they are now and to make them available on a formal rather than an ad hoc basis.

Should Section 709 of the HPEAA be fully implemented, and shared schedule residencies (and perhaps other forms of reduced-schedule residencies as well) be listed by the LCGME and matched by the NIRMP, we can predict that there will be an increase in the number of reduced-schedule residents. However, there is no satisfactory basis on which to estimate the number of medical graduates who would choose such training. While several studies have indicated general interest in part-time graduate medical education,[10,11,12] the difference between favoring part-time residencies in response to a questionnaire and actually electing such training may be substantial. What these studies do indicate, however, is general acceptance among medical students of the concept of reduced-schedule training.

Perhaps the best data regarding potential use of reduced-schedule training have been gathered, inadvertently, by the HRSRP. Between February 1976-June 1977, the Project received almost 2000 unsolicited requests for information and for copies of Institutions Offering Reduced-Schedule Training, most of them in response to brief references to the work of the HRSRP in such publications as Pulse and The New Physician. These requests reflect more than a casual interest, considering the initiative involved in writing for information and the investment of two dollars for the Directory. The Directory has also been distributed to deans of student affairs and of clinical affairs at every medical school accredited by the A.A.M.C. so that many more students can take advantage of the Project's materials as made available at their own schools.

We can reasonably expect an applicant pool for shared schedule residencies and other forms of reduced-schedule training much in excess of 100-200 part-time house officers per year. Based on currently available data, however, accurate predictions as to the number of students who would select reduced-schedule training, were such training readily available and well integrated in the system of graduate medical education, cannot be made. Surveys of graduates of part-time residencies cannot predict future users. We can, however, examine the models proposed for shared schedule training in terms of graduate medical education in general, and thus begin to anticipate some of the issues pertinent to individuals pursuing post-graduate medical training on a shared schedule basis.

Reduced-Schedule Residencies: Issues for Discussion

Five major areas of concern must be considered in a discussion of reduced-schedule residencies in the overall context of graduate medical education. These include patient care and continuity of services, quality of education, financial feasibility and restraints, attitudes of full-time house staff and other physicians and the necessary degree of intensity of training in medicine. Comments germane to each of these issues follow, with specific reference to training on a shared schedule basis.

Patient Care and Continuity of Services

The shared schedule model described above and incorporated in the HPEAA was formulated to provide overlap time adequate to ensure continuity of patient observation and care (or of analogous services, such as those performed by pathologists). Continuity of care must be seen in context of both inpatient and outpatient services. Thus, to be successful, shared schedule training must provide continuity of care in a manner suitable for and acceptable to hospitalized patients and to ambulatory care patients.

In addition to ensuring continuity of care from the patient's viewpoint, one must also consider the viewpoint of the residents themselves. The arrangements necessary for the provision of quality care with continuity of services have been used by group practices for many years; in fact, shared schedule residencies may provide especially good training for physicians intending to pursue this kind of practice. Questions relevant to continuity of patient care and type of practice are addressed by Eugene Farley, M.D., Director of the Family Medicine program at the University of Rochester School of Medicine:

> We developed the pairing system in this Family Medicine Program to assure the ability of the residents to provide continuity of care to their (clinic) patients in the practice while assuring coverage of in-patient needs on the wards.... The objectives of such pairing are not only to assure complete patient coverage without overstretching and stressing the resident but to teach doctors to learn to share, work with and cover for each other while assuring continuity of care of their patients. We believe it prepares the residents much better for a rational type practice and life style in areas of need than the traditional, independent, unpaired, solo training. At the same time these residents must learn to work with nurse practitioners and physician assistants so they can handle the number of patients assigned to them for their whole time in training in a way that assures there is time for quality care which includes dealing with the psycho-social, as well as dealing with quantity of care which relates to the pressures for care from the community.

Evaluation of the experiences of the Family Practice programs at Montefiore, Seattle, and Rochester will provide valuable data with reference to continuity of patient care provided by paired residents. Such evaluation should lead to suggestions for optimizing patient care and continuity of services provided under the shared schedule model.

Quality of Education

The educational objectives of residency training are of primary importance; shared schedule residencies, in order to provide first class training, must allow house staff to participate in all the educational situations offered to full-time residents: structured, scheduled educational events, such as rounds and teaching conferences, as well as clinical experience, reading, and medical investigation. As with patient care issues, the shared schedule model provides overlap time to allow both "halves" of a shared position to participate in these educational activities.

Because the educational aspects of residency training extend beyond structured and scheduled events, it is essential that each half of a shared residency undertake both night and weekend duty. Research is needed to determine whether the shared schedule model, in which two residents split night and weekend work of one position, provides an adequate amount of night and weekend call. Here, again, data from the Family Practice programs at Montefiore, Seattle, and Rochester would be valuable.

Shared schedule residencies may broaden the educational perspective of residency training by allowing more time for assimilation of clinical and other related experiences, as well as allowing time for reading and clinical investigation.

Financial Feasibility and Restraints

Financial feasibility was an important consideration in the development of the shared schedule model, which stipulates a minimum of one full salary and two benefit packages in compensation for two residents working 133%-150% of a full-time position. However, future standards of financial feasibility may be altered by cost containment legislation in general and by the pressure to reduce hospital and medical care costs. Whatever the specific legislation enacted, graduate medical education as a whole is likely to be affected significantly. The shared schedule model must be considered from the perspective of cost containment, and the quality of care delivered and education received balanced against the increased cost of an additional benefit package.

Attitudes of Full-Time House Staff and Other Physicians

Assuming the model for shared schedule residencies to be well-conceived and financially feasible, fulfilling the educational purposes of residency training and providing excellent patient care, one must still consider the reactions of full-time house staff to their part-time colleagues. It is not unreasonable to expect resentment, envy, or even open hostility toward shared schedule residents. The extent to which these attitudes are expressed will depend in great measure upon the commitment of the program director and staff to the concept of shared schedule training and the degree of integration of such training in the program. Similarly, unless they are fully integrated in the system, shared schedule positions may be undervalued as "second class" training.

Shared schedule residents who are well satisfied with the quality of their graduate medical education may, nonetheless, feel excluded from the camaraderie and fellowship that is part of the traditional residency training groups. It has also been suggested that shared schedule residents may experience discrimination with respect to career advancement opportunities, such as prestigious fellowships or academic appointments that are available to full-time house staff. An informal review of the professional accomplishments of some of the women who have pursued graduate medical education on a part-time basis reveals many to have been eminently successful. Nonetheless, an important safeguard against shared schedule residents being regarded as receiving second class training or as somehow less worthy of career advancement, is to ensure that their training is on a par with that received by their full-time colleagues--and well integrated in the sponsoring program.

Issues Related to Intensity of Training

While the shared schedule training model incorporated in the HPEAA was designed to provide training of comparable quality to that received by full-time residents, there is one dimension on which shared schedule training differs substantially from traditionally scheduled training: the degree of intensity of training. If one accepts the current scheduling of many primary care programs as providing the minimum degree of intensity of training (i.e. on call every third night and off every third weekend) any less strenous schedule will not be adequate. The argument in favor of high intensity training is related to the inculcation of the quality of dedication in the physician-in-training. This argument is stated well by David Heinbach, M.D.,[13] Director of the Surgery clerkship program at University of Washington School of Medicine, in terms of the need for medical students to undertake their clinical clerkships on a full-time basis; in summary:

> Medicine is a demanding mistress. In my opinion, the ideal physician still puts the patient first. The patient comes before dinner guests, sailing, and yes, even before family. The competent practice of clinical medicine interferes with everyone's life style. I miss countless dinner parties, commonly only see the first half of a motion picture, and frequently come home after the children are in bed and leave before they get up in the morning...The primary physician's responsibility extends through day and night, on weekends, holidays, and on sunny days and rainy days. When something happens to that patient he must be available and willing to respond promptly.
> Although this responsibility extends throughout clinical medicine, it is on the primary care services such as internal medicine, obstetrics-gynecology, pediatrics, and surgery where it is most time consuming. A major goal of each of the clerkships (and residencies) is to instill in the student the attitudes required for the rest of his life as a physician. If you...do not develop them during your clerkship (or residency), you may escape exposure to this responsibility forever.
> And, since this responsibility is the very foundation of all of medical practice, I cannot permit anyone to escape it. Without such attitudes no one deserves the degree of Doctor of Medicine. (pp. 104-105). (bracketed inserts added by authors)

The major question here is how to train physicians to be dedicated, or whether in fact, this is even possible. Is a physician who works 100% of time a better physician for that reason? Is that doctor's patient better served and more secure? Should the system strive to develop a cadre of physicians commited to this kind of service? Can a training program that demands the maximum intensity of training experience in terms of hours continuously on duty be seen as the optimal means of raising a generation of compassionate and competent doctors?

The sleep deprivation concomitant with the intensity of training involved in traditionally scheduled residencies also should be considered. The investigation of Friedman et al.[14] indicated that "work schedules that "deprive interns of normal sleep not only may produce negative mood changes and transient psychopathology, but also may impair efficiency of performance." Wilkinson et al[15] surveyed 6500 house officers in England, Scotland, and Wales asking, among other questions, "Do you think your hours of duty are so long as to impair your ability to work with adequate efficiency?" Of the 2452 respondents (37.7% response rate), 3.3% answered "always," 34% "often," 47.6%, "occasionally," 12.2% "rarely," and 2.9% "never." Quentin Young, M.D., Chairperson of the department of Internal Medicine at Cook County Hospital (Chicago) questions the "presumption that the internship is a total immersion that excludes everything else for a trainee, a 'rite of passage' from student to doctor."[16]

As with many other aspects of graduate medical education in general, there are strongly held views and few data to be used in a comprehensive discussion of necessary intensity of residency training and how to train physicians to be dedicated. Until more research is undertaken and more data are available, inferences about how aspects of residency training correlate with the inculcation of traits desirable in practicing physicians need to be made with caution.

Conclusion

Most people would agree that the goal of graduate medical education is to train competent, compassionate, and dedicated physicians. Insofar as scheduling can have an impact on the cultivation of these qualities, it is important to attempt to determine optimal scheduling patterns for training purposes. However, we have few sources of accurate data to use to determine such optimal scheduling patterns for graduate medical education programs.

The shared schedule model for residency training is a carefully thought out alternative to traditionally scheduled programs. It was designed to meet the requirements of high quality graduate medical education, insofar as these requirements could be determined. Integration of shared schedule residencies into our system of graduate medical education will afford the opportunity to examine scheduling alternatives, while meeting the needs and desires of a growing number of medical students.

The concept of shared schedule residencies deserves a fair trial. In order to accomplish this, such training should not continue to depend on ad hoc arrangements. Shared schedule training must be integrated in the structure of graduate medical education, both nationally and in individual programs.

With respect to Section 709, several procedural steps are in order. First, it is essential that students have the opportunity to apply for and match to shared schedule residency positions through the NIRMP and that the shared schedule option, structured in compliance with Section 709 and part of an accredited residency training program, receive approval from the Liaison Committee on Graduate Medical Education. Further, the "Essentials of Approved Residencies" should be revised to allow physicians to undertake training on a shared schedule basis for reasons beyond those currently specified. Without these changes, shared schedule residencies can only remain a special arrangement for a small minority of students, apart from the mainstream of graduate medical education.

Beyond these immediate procedural matters lie the long-term issues: more research needs to be undertaken, and questions of evaluating shared schedule and full-time house officers must be addressed and pursued. We hope that this paper has provided the impetus for such research.

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The preliminary thought and work that made the Reduced-Schedule Residency Project possible was done by an *ad hoc* group of Harvard Medical School students and faculty in 1971-73. During the following three years, this work was done under the auspices of the Joint Committee on the Status of Women, funded by Harvard Medical School, Harvard School of Dental Medicine, and Harvard School of Public Health. The current work of the Project is funded by the Rockefeller Family Fund.

FOOTNOTES

[1] Joint Committee on the Status of Women. Directory of Institutions Offering Reduced-Schedule Training. Harvard Medical School, Harvard School of Dental Medicine, Harvard School of Public Health, April 1976.

[2] This general format and four specific models were previously described in: Shapiro, Eileen and Shirley G. Driscoll, "Reduced Schedule Residencies: Innovations in Graduate Medical Education." Journal of the American Medical Women's Association, in press.

[3] Smith, Alice Kimball, Radcliffe Institute 1960 to 1971. Cambridge, Massachusetts, June 1972.

[4] Joint Committee on the Status of Women, Annual Report for 1974-75. Harvard Medical School, Harvard School of Dental Medicine, and Harvard School of Public Health, 1975, pp. 18-20.

[5] American Medical Association, Institutuions Offering Graduate Medical Education on a Part-Time Basis. Chicago, Illinois: American Medical Association, 1974. This directory, available on request from the A.M.A., includes information on whether the part-time training is available to men or women or both. See Appendix A for sample page.

[6] Discrimination in employment on the basis of sex is prohibited by Title VII of the Civil Rights Act of 1964 as amended; discrimination in admission of students on the basis of sex is prohibited by Title IX of the Education Amendments of 1972 (Higher Education Act) and by Titles VII and VIII of the Public Health Service Act (as amended by the Comprehensive Health Manpower Act of 1971).

[7] American Medical Association, "Special Studies in Graduate Medical Education." Journal of the American Medical Association, 234:13 (1975), reprinted in Directory of Accredited Residencies, 1975-76, pp. 36-37.

[8] Liaison Committee on Graduate Medical Education, "Essentials of Approved Residencies." In American Medical Association, Directory of Accredited Residencies, 1975-76. Chicago, Illinois: American Medical Association, 1976, p. 335. The entire section pertaining to part-time programs is given in Appendix B.

[9] PL94-484, "Health Professions Educational Assistance Act of 1976."

[10] Howell, Mary C., "Patients and Family: What Does 'Reponsible' Mean?" Harvard University, 1974. Published in summarized form as "Stop the Treadmill...We Want to Get Off." The New Physician, November 1974, pp. 27-30.

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THE CREATIVE LEADERSHIP TRAINING PROGRAM FOR NURSES: VIEWPOINT OF A STUDENT WHO BECAME AN INSTRUCTOR

Jacquelyne G. Gorton

The Creative Leadership Development Program was initially funded by NIH Training Grant No. D10 NU 00638 for a five year period from 6/1/71 to 6/30/76. (See Claus and Bailey, 1976.)

THE CREATIVE LEADERSHIP TRAINING PROGRAM FOR NURSES: VIEWPOINT OF A STUDENT WHO BECAME AN INSTRUCTOR

Jacquelyne G. Gorton

I. The Student Perspective

A. Attraction to Course as a Student

1. Based on knowledge of the nursing profession and the leadership program.

As a student, I was initially interested in the leadership course series because I agreed with the instructors' basic premise that all nurses function as leaders. Nurses act as leaders in that they successfully manage a team of health care professionals and utilize a professional knowledge base to administer quality patient care. I realized that a course to build nursing leadership skills was needed because many nurses graduated from programs that develop their professional knowledge base without building their leadership skills. I also knew that there was a need for top level nursing leaders in the educational and practice settings (Leininger, 1974) and that there was a lack of leadership training programs nationally. Since I planned on assuming a supervisory position at a community mental center, I wanted to prepare myself for the responsibilities of that top level position.

Therefore, a course that could provide nursing leadership skills, that was funded by a five-year federal grant and which was highly acclaimed in our School of Nursing seemed ideal to me. I was already aware of the reputation of its instructors who had developed our undergraduate curriculum based on the problem solving process (Bailey, et al, 1973) and was impressed with the extensive theoretical framework presented in the course bibliography. It demonstrated a strong grounding in the theory and techniques of corporate management and ranged from the cognitive perspective of Kurt Lewin's force field analysis to a human relations focus as explained by McGregor's Theory X and Theory Y.

2. Based upon application of course content to development of my professional specialization.

As a graduate student seeking her master's in adult psychiatric nursing, I found many of the leadership course objectives applicable to the development of my psychiatric nursing expertise. The emphasis on the development of one's strengths supported my own approach to the therapeutic relationship. How the small group process would be used to facilitate several behavioral changes was of special interest to me. I was impressed with the program's intention to use the small group as the means to develop support networks and to integrate interpersonal and communication theory with successfully functioning people who would be positive forces in the field. And, I was intrigued by the use of psychological testing and the chance to study and interpret changes in my own personality as indicated by such sophisticated measures as the 16 Personality Factors (Cattell, 1949) and the Personal Orientation Inventory (Shostrom, 1966).

B. What Proved to be Beneficial

1. The small group process.

Participation in the small group meetings proved to be a most profitable experience. In my small groups, I would role-play situational difficulties I was having with the project I had chosen to implement as part of my course work. The goal of my project was to increase the quantity of staff interactions with psychiatric patients on a closed unit. To reach this goal I acted as a change-agent who concentrated on utilization of interpersonal and human relations theory and techniques to change staff behavior. When my own knowledge and skills in human interactions did not seem to be producing change in others, I would present the problem to my small group. Psychodrama and video-tape replay were especially helpful to me in examining one situation in which I had felt uncomfortable about approaching several staff members regarding their lack of involvement with the patients.

By selecting several people in my group to role-play the staff members, I could openly test various ways to communicating my concerns. Feedback from these group members regarding their reactions to my verbal and non-verbal messages provided me with insights regarding the effects of my behavior on others. Also, the video-tape replay of these scenes deepened my awareness of my communication process. As a result of this input, I decided to change my behavior and tested a different way of approaching the staff people in a second role-play.

My own uncomfortable feelings about approaching those evening staff members dissipated after role-playing several possible future confrontations in the safe setting of the group laboratory sessions. In the actual hospital environment, I was successful in persuading two staff members to contract for a one-to-one relationship with one of their long-term patients.

By participating in these small group sessions, I developed leadership skills in the communication process, human relations, and ways of influencing others to successfully reach the goal of increased involvement with their patients. By sharing as nurses, our group developed trust in each other and each of us seemed to use this group as a support system in coping with various problems.

2. The Claus-Bailey Model

The Claus-Bailey Model is a conceptual model of systematic problem solving and decision making procedures developed by Claus and Bailey over a five year period and presented in the book Decision Making in Nursing: Tools for Change (Bailey and Claus, 1975). I found the model very useful in analyzing the problem situation in my change project. By using the systems approach specified by this model, I was able to maintain objectivity in evaluating circumstances surrounding the staff's seeming apathy toward their patients. One of the first steps of the model, "defining the discrepancy," was particularly helpful in preventing me from jumping to conclusions about why the staff were distant from their patients. A "discrepancy" is defined as the difference between "what is" and "what should be." Instead of stating that the staff were not interacting with their patients because they were lazy, or scared, or unknowledgeable; or instead of aligning myself with the head nurse who ordered the staff to spend more time with patients, I very simply stated what was happening - the staff were not interacting with their patients, and what should be happening - the staff should be interacting with their patients. In this way I avoided coming to a hurried and mistaken conclusion before I had actually identified the problem. The rest of the model provided an organized basis by which I could defend decisions initiated to change the staff's behavior (Figure 1).

II. The Instructor Perspective

A. The Small Group as a Means of Teaching Practical Leadership Skills

When I became a member of the instructional staff of the project, my responsibilities included assistance with the small group laboratory sessions and student counselling. It was our intent that the small group experiences would serve three purposes: 1) to reinforce teaching of the systems model and leadership theory concepts on a more individual basis; 2) to provide our students with an opportunity to apply these theories in areas of their professional focus; and 3) to serve as the mechanism by which we could develop the whole person as a leader versus limiting outselves to classroom lectures on the theoretical aspects of leadership.

All students were asked to join one particular small group convenient to their schedule. A safe framework for these group meetings was established in that no grades were assigned to group participation and students were informed that these group meetings were designed for their personal exploration of materials discussed in class. As the small group leader, I attempted to establish a risk-free environment within each group by reiterating that my purpose was to facilitate their understanding of course content and to work with them in developing leadership skills pertinent to their current nursing specialty area. A non-threatening atmosphere was also reinforced by my sharing how I would apply class concepts to my specialty area of psychiatric nursing.

The beginning sessions were spent in building group cohesion. Members described aspects of their professional background, areas in which they felt they lacked leadership skills. The working phase of the group evolved as individual members revealed and worked on problems they were having at their jobs or in school.

Problems discussed ranged from questions on the systems model to change projects involving subordinates and superordinates within various health practice settings. I acted as group facilitator by opening each session with the questions "where are you today" and "what do you wish to discuss today." In this way the students learned how to assume leadership responsibility for the direction of their group discussion. Group members would also provide direction by offering verbal or role-playing strategies for their classmates to use in attempting to solve their leadership problem. At subsequent meetings, students would relate the results of having tested the group's suggestions. Thus, the group meetings provided an opportunity for students to collaborate in developing their interpersonal competence and problem solving abilities in leadership situations.

Many students also worked on increasing their personal self awareness as they began to feel secure in our supportive group meetings. Even after formal termination of these groups, members continued to use each other as emotional and cognitive support systems in graduate school and in the nursing profession.

B. The Project Group as a Team

Our project team was my support system as well as the source of leadership for the entire project. This project team consisted of three faculty members, two secretarial staff members, and from two to four research assistants and graduate students. A spirit of cooperation was initiated when we identified our individual strengths and assumed responsibility for tasks that utilized our abilities. June's strength was in planning and organizing activities. She contributed to our successful team effort by providing project agendas and by coordinating our activities with other campus and community agencies. Conceptualization, development of training sequences, and data analysis were Karen's greatest abilities. She, therefore, was responsible for the statistical analysis of our data and worked with June on writing project reports and leadership books. My strength was in leading small groups and in counselling students. Accordingly, I led all the small groups, was advisor to graduate students and lectured on the small group process. The secretarial staff, in addition to maintaining a highly organized office, were proficient in assisting students to use the computer. The various research assistants and graduate students completed literature searches, data collection, and several pilot studies on leadership depending on their academic preparation and professional focus.

Our project team was productive not only because we utilized each other's capabilities, but also because we were sensitive to each other's needs. By having regularly scheduled meetings, we had frequent opportunities to make requests of each other and to support each other as changes occured. Participative leadership allowed everyone to mutually complete task and maintenance functions to meet the needs of our group. Task functions are assignments given to the group so action can be taken to reach group goals. Maintenance functions are those actions taken by group members to ensure interpersonal comfort in the group (Lippitt, 1969). At times one of us would initiate maintenance functions by expressing group feelings or by encouraging others to contribute their opinions. At other times, someone would assume task functions by recommending how work should be delegated or by asking for consensus. Since our group members were successful in completing both task and maintenance functions, our team operated at maximum efficiency and interpersonal comfort throughout the five years of the creative leadership training project.

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CLAUS - BAILEY
SYSTEMS MODEL FOR PROBLEM SOLUTION©

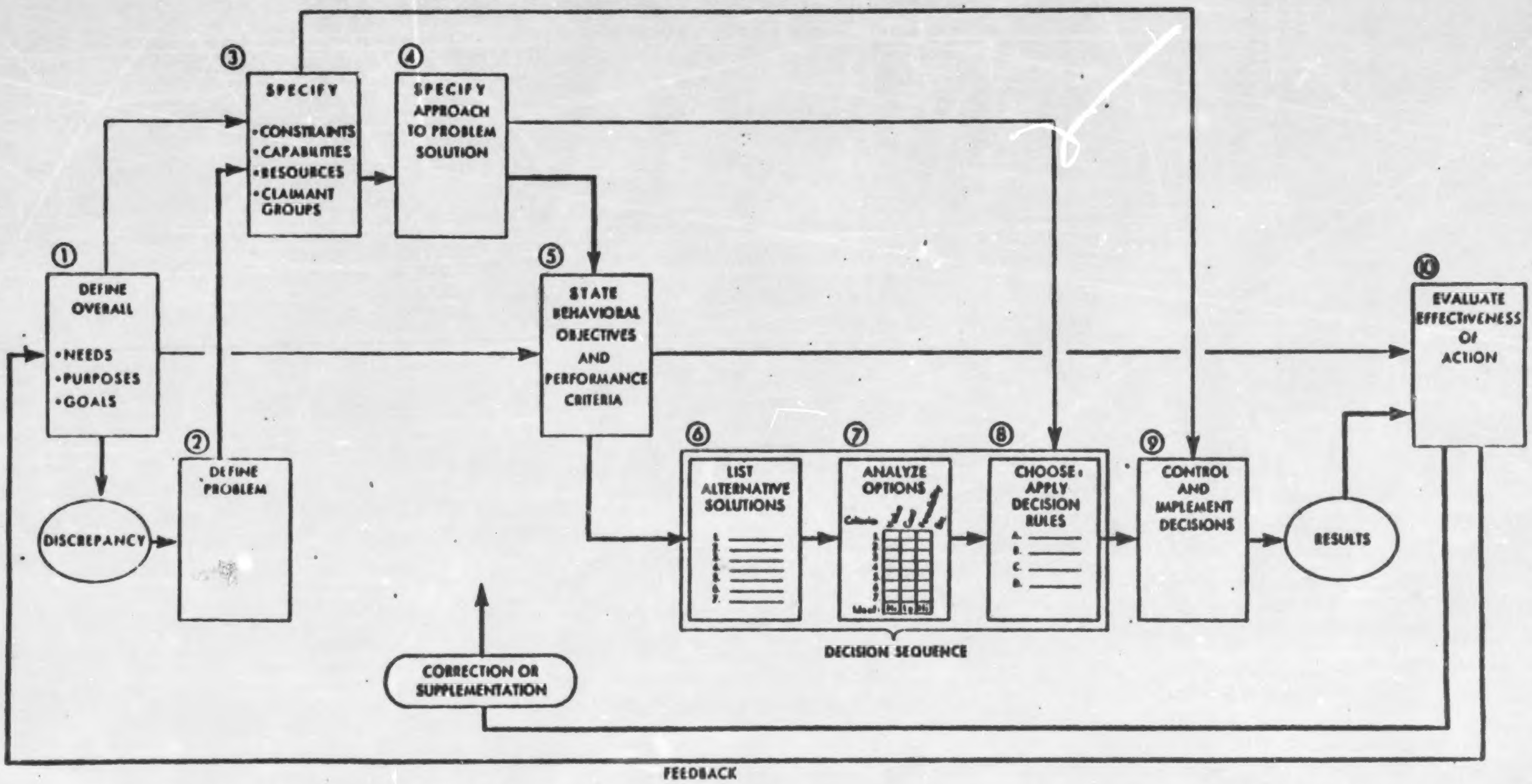
③ SPECIFY
• CONSTRAINTS
• CAPABILITIES
• RESOURCES
• CLAIMANT GROUPS
④ SPECIFY APPROACH TO PROBLEM SOLUTION
① DEFINE OVERALL
• NEEDS
• PURPOSES
• GOALS
⑤ STATE BEHAVIORAL OBJECTIVES AND PERFORMANCE CRITERIA
⑩ EVALUATE EFFECTIVENESS OF ACTION
② DEFINE PROBLEM
DISCREPANCY
⑥ LIST ALTERNATIVE SOLUTIONS
⑦ ANALYZE OPTIONS
Criteria
Model:
⑧ CHOOSE: APPLY DECISION RULES
A.
B.
C.
D.
⑨ CONTROL AND IMPLEMENT DECISIONS
RESULTS
DECISION SEQUENCE
CORRECTION OR SUPPLEMENTATION
FEEDBACK

FIGURE 1.

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X.

DIRECTIONS FOR CHANGE

As we look to the future, what steps hold promise for elevating women's participation in the health care hierarchy and their achievement of full equality as professionals?

Drawing on her research in the social psychology of women, White proposes a re-examination of the concept of androgeny as a mature form of competency, bringing into balance characteristics traditionally regarded as male or female. Ruzek raises additional issues concerning women's mobility and summarizes themes for research and action which emerged from the conference.

ANDROGYNOUS MATURITY
AND THE NURSE PRACTITIONER

Martha Sturm White

This paper was presented as part of a symposium of "Women's Careers in the Health Professions, at the Pacific Sociological Association, Sacramento, California, April 1977. The research was supported by NIH Bureau of Health Manpower Education Contract No. 72-4216 and by Grant No. 3009 from the Robert Wood Johnson Foundation; Betty L. Highly, Associate Professor, Department of Family Health Care, University of California, San Francisco, was the Principal Investigator.

ANDROGYNOUS MATURITY AND THE NURSE PRACTITIONER

Martha Sturm White

The field of health care is in a state of ferment and change today. Although it is impossible to characterize all the significant changes, many are directed toward helping health care programs to be more responsive to patient needs, to be concerned with prevention as well as therapy, and to utilize existing health professionals in a more effective and relevant manner.

These concerns have found expression in a new role which has developed in the past few years, that of nurse associate or nurse practitioner.

The nurse practitioner may work in an ambulatory clinic or with a physician in private practice. The practitioner sees patients, does initial health assessment in certain areas, counsels and gives information, and refers the patient if other skills are needed. He/she tends to focus on health rather than illness, e.g., conducts well-baby clinics or sees women during their pregnancy. Several thousand practitioners have been trained in this new role over the past 8 to 10 years.

When the opportunity was presented to me several years ago to conduct a research project on this new role, I was immediately attracted to the possibility because it touches upon many relevant concerns for one interested in both women's expanding opportunities and the function of new roles and work settings in nurturing adult personality and development. As Fagin has point out, the problems of professional nursing are the problems of women in microcosm. (Fagin, 1971)

There are, of course, many men in nursing, and there were men entering the practitioner role. However their numbers were small--only about 1 or 2 percent of the sample--and they are not included in this report since it would be difficult to preserve their anonymity.

As nursing has evolved its concept of the new role, it has emphasized 1) nursing skills in primary care; 2) independence of function, and 3) collaboration with other health professionals, particularly the physician. Here, for example, is a description of expectations of the role of primary nurse practitioner as set forth by three faculty members at the University of Washington: "...makes initial health assessments by taking health care histories, ...functions as an independent nurse practitioner within the broad concept of nursing practice, ...makes referrals and collaborates with physicians and other health disciplines according to the needs of the client, his family or social group, ...uses and communicates client-community data, ...provides continuity of health care services, ...formulates individual and group nursing plans and carries out these plans through a variety of interventions including health counseling and teaching, ...explores clues related to the prevention of illness, ...critically examines and modifies activities related to the...role." (Leininger, Little, and Carnevali, 1972, pp. 1276).

In the actual training programs, physicians act as preceptors in teaching health assessment skills. Nursing faculty preceptors monitor the practitioner's effectiveness; skills in counseling and understanding of family dynamics are a part of the curriculum. In short, nurse practitioners learn how to carry out some procedures formerly done by physicians, but also learn to incorporate them into an added nursing definition of good care.

Such a significant role reorientation is not accomplished without a great deal of anxiety, and the training period is often a stressful and conflictful time. Being the primary care provider means taking full responsibility for many initial decisions about the patient and this function is a new one to many nurses. Although consultation with a physician is always available during the training program, by the end of the program the practitioner will have had to learn when she needs to avail herself of this consultation and when to make decisions herself. There is a gradual process of learning risk-taking, with increasing responsibility for decision.

During interviews, the faculty in our program at the University of California in San Francisco were asked what characteristics they thought were important in potential practitioners. Their replies stressed the importance of qualities such as maturity, enjoyment of authority, confidence in talking to patients, responsibility, independence, assertiveness, and a liking for patient care.

I found it intriguing that this new role seemed to be attempting to combine not only aspects of the medical role and the nursing role, but aspects of the so-called "masculine" role and "feminine" role. That is, the nurse practitioner was expected to be assertive, independent, and autonomous, and to combine this with being caring, responsible, and supportive.

Would nurses who had or who gained skills in both these areas be better practitioners? Or rephrasing in terms of the topic of my talk, would those who were androgynous, who combined assertiveness with warmth and sensitivity, be better practitioners?

To test this I needed a measure of androgyny. I was soon to realize not only that no suitable measure existed, but that the research in the field of sex differences was in a shambles. Most studies have been of college age students or of children, have used stereotypes rather than actual self-concepts or behavior, have discarded qualities or adjectives which men and women share or believe both sexes to have in common, and have lacked any developmental perspective which might cause one to ask if age or maturity had any effect on ability to combine both qualities (White, 1977).

In contrast, in my study I was interested in adult women in their twenties, thirties, and forties, and in their actual self-concept or behavior. I wanted to describe women who might possess both so-called "masculine" characteristics such as assertiveness and independence, and "feminine" characteristics such as sensitiveness and understanding. I believe that being strong in assertiveness did not necessarily mean being weak in sensitiveness, but that many men and women had both. I agreed with the many critics who have emphasized that these are not opposites or bipolar characteristics. Although my sample was a limited one, it seemed that it might be a highly significant one to study, since all were women originally in a role thought of as traditionally female.

Developing a Measure

Over the past several years several excellent articles (Constantinopole, 1973; Carlson, 1971; Jenkin & Vroegh, 1969; Block, 1973; Heilbrun, 1976; Spence, Helmreich, & Stapp, 1975; Bem, 1974) have appeared justifiably raising questions about the bipolar nature of the sex role dimensions which has characterized much of the sex differences research. It has been suggested that there is not a single continuum with masculinity and feminity at opposite ends, but that these represent separate dimensions, and may overlap. And some investigators have suggested that the ability to combine these two aspects of the personality may be an important characteristic of development or maturity (Jung, 1933, pp. 95; Neugarten & Gutmann, 1958).

Recently there has been renewed interest in measuring androgyny, as this particular combination of traits has come to be called. French and Lesser (1964) were perhaps among the first to note that women high in both masculine and feminine characteristics had higher self-esteem. Their work was corroborated more recently in the work of Spence, et al., (1975), who have developed a measure of androgyny, as has Bem at Stanford (1974). I have especially liked what Spence and her group have referred to as the "additive" approach. This method distinguishes a high androgynous group (high on both masculine and feminine characteristics on some measures) from a low androgynous group (not high on either), from a masculine group (high only on masculine characteristics, and a feminine group (high only on feminine characteristics). I would expect the androgynous group to be superior to the masculine-only or feminine-only group on such measures as self-esteem, competence, or coping skills. However a number of studies find little difference between the high androgynous and the masculine group.

As with any measure in the early stages of development, there are still problems and difficulties with these measures. I find the terms "masculine" and "feminine" confusing and value-laden and prefer not to use them. Most measures have been developed using college students in their early twenties, and seemed to embody somewhat age-specific concepts of femininity. Both negative and positive traits are mixed indiscriminately in together.

In attempting to define and measure androgyny, I have become interested in the distinction made by Bakan (1966) between differing tendencies in men and women which he called agency and communion. (See also Carlson, 1971 and Block, 1973.) By agency, Bakan seems to be referring to self-assertive qualities: themes in which the self as a "doer" is emphasized. Communion refers to union, receptivity, and altruism. Both agency and communion may be present in either men or women. They may overlap or fuse as well. He suggests however, that women tend to have both agentic and communion qualities more frequently than do men.

Of particular interest is his concept of "unmitigated agency." This represents an over-determined or out-of-control assertiveness of individualism which has negative consequences for other people. In his schema, one might have either too little agency, an appropriate amount of agency, or show characteristics of unmitigated agency. He implies that similar parallels exist for communion, but these parallels are not well developed in his discussion.

In my own research, I began to think of the agentic and communal distinction as describing competencies which individuals might possess. I had become dissatisfied with Broverman, et al.'s (1972) use of the word "competencies" to describe only "masculine" qualities. Nor had I found the terms "instrumental" and "expressive" helpful, but only confusing. Many of the qualities commonly put under expressive seem just as capable of accomplishing actions in the interpersonal sphere as those put under instrumental. "Tactful" seems as instrumental as does "competitive." "Talkative" seems no more expressive than "active."

Though Bakan stresses the negative consequences for individuals of "unmitigated agency," he does not explore the consequences of "unmitigated communion." Yet this is a relevant dimension which merits more concern. Excessive denial of self and over-dedication to others' welfare are on an equivalent form of problem-producing tendencies and immaturity. Perhaps the problem is that we cannot easily differentiate between excessive and "normal" concern for the helping of others, the facilitation of action. Most sex difference scales use terms of descriptions which seem descriptive of "unmitigated" communion or regressive qualities: "devotes self to others;" "childlike."

In Bakan's theory, agency and communion mitigate each other. That is, agency unmitigated by communion can be a destructive force. Communion unmitigated by agency can create problems. Each needs to be "mitigated" or leavened or tamed by the presence of the other. I wished to develop a measure which would allow me to measure both unmitigated agency and unmitigated communion, and a strong mitigating combination of each which I thoughtof as androgyny, and a weak combination of each, which I thought of as either immaturity or inadequacy. In this paper, I should like to report on my efforts to develop such a measure, and to learn if it would discriminate in a meaningful manner in describing the nurse practitioners. I shall describe the measure I used and some of the relationships which seem to substantiate its validity as a measure of androgyny.

The Sample

This study is part of a larger project concerned with the assessment of nurses in a special nurse practitioner training program. The sample consisted of 139 women who were training to become either pediatric or maternity nurse practitioners. Most were registered nurses and had several years of work experience. Ninety-six were in a five-month continuing education certificate program and the remainder were completing a baccalaureate or a master's degree in nursing. The median age was 29; however, the range was between 22 and 49 years. Of those in the continuing education program, 37 had a diploma or associate degree; 49 had a baccalaureate degree, and 8 had a master's degree. The data was gathered from four different groups over a two year period.

Method

The trainees were given a series of personality tests upon entry to the program; these included the Adjective Check List (Gough), the California Personality Inventory, the Rotter Internal-External Locus of Control Scale, and the Personal Orientation Inventory. In addition, they also took the White Nurse Practitioner Competency Test, on which they indicated whether they felt competent in certain areas relevent to their practitioner training, such as counseling patients, and working with physicians. At the end of the training period, a number of other measures were given including an interview and a repetition of the Nurse Practitioner Competency Test. Additional follow-up studies were conducted, which will not be reported here.

Results

Since I was attracted by Bakan's (1966) differentiation of agency and communion, and by his assertion that each of these qualities needed to be mitigated or leavened by the other, I sought to measure these dimensions. My first attempt used an adjective list (White, 1977); this was reasonably successful, but had some problems. More recently I have been working with another measure of androgyny partially based upon a factor analysis of the California Personality Inventory (Gough, 1957).

Many investigators have conducted factor analyses of the California Personality Inventory (Megargee, 1972), and find approximately the same factors as we found when we factor analyzed our sample. The first factor, which accounted for 22% of the variance in our sample is one made up of scales very similar to what we have called communion. Women high on this factor are responsible, controlled, conventional, nurturant, and tolerant. (The CPI scales are Wb, Re, Sc, To, Gi, and Ac.) The second factor which accounted for 19% of the variance is composed of the more outgoing, assertive scales of the CPI (Do, Cs, Sy, Sp, Sa). It seems similar to Bakan's agency dimension. Women high on this factor are confident, assertive, and enjoy the limelight. I called those high on the first factor, Reliable Responsibles, and those high on the agentic factor, Dominant Individualists. Together these two factors accounted for 41% of the total variance of the test. Since I believed androgyny to be the outcome of agency mitigated, or combined, with communion, I wanted to compare not just individuals who were high on one factor or the other, but also those who were high on both factors. In addition, I wanted to also look at those who were not strong on either factor, and who might be said to lack either agency or communion.

An analysis of variance was run comparing four groups: those above the mean on both factors; those above the mean on Reliable Responsibility alone; those above the mean on Dominant Individualism alone; and those below the mean on both factors. I thought of these groups as the Androgynous Mature, the Responsibles, the Dominants, and the Inadequates. It proved to be a very powerful typology.

In addition, a Hays Planned Comparison between means was done for two contrasting groups: the first, between those high on both variables, and those low on both variables; and the second, between those high only on Dominance or in Responsibility. Results are reported only if they are significant beyond the .05 level.

I will also report only some selected results since we found an overwhelming number of significant differences. Let me begin by telling you how each of these groups described themselves, and then go to report how they differed in innerdirectedness, and in self-perceived competency in nurse practitioner skills.

Validity

The adjective which each of these groups used to describe themselves give a great deal of support to the notion that these scales are measuring the more abstract concepts of androgyny, agency, and communion. It must be remembered that this is a fairly select group, and that they have very positive and strong self concepts. In all four groups, over 85% of the trainees used adjectives such as the following to describe themselves: friendly, affectionate, healthy, cooperative, active, and adaptable. However, it is useful to examine those adjectives which each groups used more or less than the average. (The criterion was a difference of at least 10% from the mean on a word that was frequently used.) The Androgynous (or High Responsibles-High Dominants) group were more likely to use the following adjectives: confident, contented, easy going, energetic, optimistic, outgoing, spontaneous, stable. The Responsible group were more likely to describe themselves as reserved, leisurely, modest, progressive, quiet, relaxed, shy, and warm. They were less likely to see themselves as curious, individualistic, or stable. They seem to be describing themselves as quiet, conventional, caring people. The High Dominant Individualists groups used more adjectives such as alert, resourceful, foresighted, complicated, clever, defensive, deliberate, demanding, humorous, impatient, initiative, and moody. They were less likely to use self-descriptions such as emotional, generous, pleasant, sociable, or tolerant. There is a shrewd, slightly hard edge to their self-description—"I am always sizing things up to see what's in it for me." Finally our fourth group, who are below the group mean on both factors. They see themselves as adventurous, aggressive, anxious, argumentative, and emotional. The list of least-used adjectives is long: they are less likely to see themselves as mature, realistic, forgiving, loyal, attractive, energetic, good-natured, feminine, resourceful, natural, optimistic, or peaceable. This list seems to point to more problems than good points.

These self-descriptions reinforce the conclusion that the measures chosen to represent agency and communion, indeed, seem to do so. Furthermore, when the two factors are combined, they appear to augment each other in such a way that outstanding personality qualities are the result, with extreme and undesirable tendencies modulated.

It should perhaps be noted in passing that there is an effect for age between these groups: those high on the Responsibility factor are a little older than those high on Dominant Individualism. While this might be a result of maturity, it may also indicate that older nurses (average age 33.4) might simply have been trained in an earlier era.

Two tests were administered which measure an internal sense of directedness: the Internal-External Locus of Control Scale, and the Inner-Directed Scale of the POI. In each of these, the androgynous mature group is most inner-directed, though a significant difference between means is only found between the Androgynous and the Inadequates.

Finally, let us see how these personality styles affect their self-perceived competency skills as a nurse practitioner. These were measured both on entry into the program, and at the end of the training program. Practitioners were asked about their competencies and skills in four areas; these were then summed for a total score. (N=96 and includes only continuing education students.) Upon entry there is a significant effect for all competencies. In all cases, the Androgynous group sees themselves as most competent, and are significantly different from the Inadequate group. They are superior in counseling patients, in relations with other staff, in working with physicians, in satisfaction with current role, and in total competency score. The Dominants and Responsibles have fairly similar scores, although the total score is lower for the Dominant group than for the Responsibles.

A more important test for competency comes when they leave the program. Although everyone's score is higher, the order is very similar. The Androgynous group feel themselves to be most competent in every area, including clinical skills, and are still significantly different from the Inadequates, who have the lowest scores. The Dominant group's scores have come up and are now equal to those of the Responsible group.

Implications

What are the implications of this study? To faculty who are interested in selecting good candidates to become practitioners, it must be reassuring to note that the qualities which they selected as denoting a good practitioner actually do so. When we look at those students who upon entering the program were independent, assertive, caring, responsible, and empathetic human beings, we see that they are superior in many ways. (Some of the unreported results indicate that they are superior in intellectual capability and in coping skills as well.) On the other hand, I don't think these findings necessarily mean that tests such as the CPI should be used to select candidates. The faculty seem to have done a good job, but perhaps a study such as this can help sharpen their judgments. Some of them believed autonomy and assertiveness were qualities that must especially be sought in the practitioner; our results show that these qualities alone may be characteristic of an individual limited in some ways. However, it is also clear that several fairly distinct types of personalities are drawn to the practitioner role, perhaps for different reasons, and so far the evidence seems to suggest that they may each make different contributions, or possibly work in different health care settings. It is too early to exclude either the Responsibles or the Dominants. With greater certainty, we can exclude those who are neither Responsibles or Dominants, but again I would offer a caution. It is only those with scores which are very low who seem to present a problem; we should be most cautious about those whose scores are below the 30th percentile on one or more scales.

To those who are interested in a measure of androgyny, I think this measure commends itself in both power and promise. It seems a useful tool to measure change in people in a new role such as the practitioner role since it appears to be valid and it discriminates between important groups. The real test will come when we look at the two year follow-up measure and see what changes have taken place, and who is still active and committed in the role. Our original hypothesis was that women with androgynous competencies would do best as practitioners. This has been supported.

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WHERE DO WE GO FROM HERE?

STRATEGIES FOR CHANGE

Sheryl K. Ruzek

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WHERE DO WE GO FROM HERE? STRATEGIES FOR CHANGE

Sheryl K. Ruzek

Constraints on women's exercise of leadership and authority in the health professions have been documented thoroughly. Now we must ask, what can be done? What types of research, public policies, programs, and political action can move women into leadership roles and facilitate their effectiveness in these positions? What structural changes on a societal level and within work organizations would be useful? How can we--on an interpersonal level--behave in ways to counteract either blanket or subtle forms of sex discrimination? This paper reviews strategies suggested by conference participants to facilitate women's upward career mobility and increase their role in policy and decision making.[1]

When considering strategies, we must ask what the consequences and costs of certain actions will be--both for individuals and the society as a whole. During periods of transition when old roles and rules are giving way, forging new roles and fostering new forms of social organization is risky and carries a price. On a personal level, women may feel burdened by conflicting obligations and fear that their upward mobility will have a deleterious effect on their intimate relationships with men. In their work settings, women may face hostility of both male and female subordinates--a situation causing both personal discomfort and reduced capacity to work efficiently and effectively.

But there may be more generalized societal costs as well. We especially must ask what effect professional women's mobility has on clients or patients and on other aspiring groups, particularly ethnic minority groups and women in lower-status occupations. We must carefully examine areas in which we cooperate, form coalitions with others, compete, obstruct, or react idiosyncratically. We have not adequately considered the specific circumstances under which professional women's interests--particularly white professional women's interests--do, indeed, conflict with the social change and personal mobility aspirations of others.

Raising the issue of conflict of interest violates some feminists' comitment to the ideology of equality and sisterhood among all women. While sisterhood is powerful, so are class interests and ethnic and religious commitments. These conflicting interests must be explored more openly or we remain stalemated by our ambivalence over elitism and egalitarianism and the use of "male models" of power for advancement. This ambivalence is clear in our concern that upward mobility not be gained at a cost to others even more oppressed than ourselves. In the long run, it is better to acknowledge potential conflicting commitments, so that we can consciously and deliberately choose whether or not the consequences and costs of specific actions are or are not acceptable. Until we at least entertain the idea that mobility might be detrimental to others, we will be hampered in our attempts to assess whether we do, indeed, want to move up. Clarifying this issue would also enable us to plan strategies to minimize conflicts of commitments.

Overview of Strategies for Gaining Power

If women are to assume major positions of leadership and authority and exert power in proportion to their numbers in society, major social institutions require restructuring. For without changes in family roles, normative career patterns and expectations, the educational system, and more general cultural values and expectations, women will continue at a disadvantage to men in assuming leadership positions. In short, strategies for promoting women in health careers must be considered as part of a broader set of strategies to improve the status of women in society.

Although changing major institutions and values is essential, it is difficult to accomplish. Progress is slow, for small changes must be accomplished in institution after institution on every level of social organization. From national policy to interpersonal relations, change must be instituted. By examining strategies used by other groups intent on changing women's roles and status, we discover a range of strategies useful in the health arena to increase women's power and influence and enable them to combat discrimination. These strategies are intermediary level actions which can improve conditions for women in health occupations and professions in traditional institutions on an ongoing, day-to-day basis, as well as in the long run. They specifically aim at developing women's influence in what de Tocqueville termed secondary sources of power--institutions that mediate between society and the individual.

Moving women into powerful positions in established institutions is fraught with hazards, and must be understood within the context of both group and individual values and world views. For when an individual assumes a leadership position, she may be defined as having achieved upward mobility and success or as having been coopted. Similarly, when change-oriented groups' recommendations or programs are integrated into established institutions, pressure groups involved in the process may be seen as becoming either institutionalized or coopted.

How others define women's mobility and how women juggle their dual commitments to outside pressure groups and inside power structures creates cross-pressures on upwardly mobile individuals. If the individual is defined as successful, or a program defined as institutionalized, a degree of routinization and pursuit of larger institutional goals and practices will be both accepted and expected. Women in such positions will be applauded by their colleagues and at least tolerated by their superiors, once convinced that women can indeed become "members of the team."

On the other hand, individuals or groups defined as coopted face tremendous personal and professional conflict. Feeling compromised by sacrificing the values and goals of an important outside reference group creates self-doubt and lowers self-esteem. Resisting the definition of self as coopted, by attempting to maintain solidarity with outsiders, hampers one's credibility with insiders, while at the same time leaving the individual vulnerable to repeated attacks by outsiders who question her politics and values.

Any individual or group accepted into the established power structure will, to some degree, be coopted. Because of this, activists often take an ideological stance that real change can only come from outside. While certainly pressure for change must come from outside, insiders, particularly newly incorporated marginal individuals, are often effective change agents.[2] In short, it seems more productive to examine how insiders and outsiders can develop reciprocal or mutually acceptable strategies than to debate the desirability of being inside or outside.

Furthermore, an individual is rarely exclusively an insider or outsider. For example, a woman physician on the clinical faculty of a medical school will be an insider vis-a-vis female students, but possibly be an outsider as a member of a coalition of women's groups attempting to get university approval for special programs for women. Nonetheless, professional women with even nominally official positions in powerful institutions are often defined as absolute insiders by outsiders who do not recognize these women's lowly status within the actual institutional power structure. As in other situations, the higher one is in the stratification system, the clearer one sees fine distinctions in power and status.

Just as the debate over insiders and outsiders can divert us from working together, so can debate over whether individual or group efforts are more effective for facilitating change. There is a need for both. In some situations, a powerful individual can accomplish much. For example, a respected senior faculty member's comment that she or he hopes a sexist statement or pejorative reference to women or minorities will not be heard again in a faculty meeting or class can be extremely effective. While the senior person may have acquired this sensitivity to women from group action, she or he need not be a group member to be effective.

On the other hand, powerful individuals are not always available. Or changes desired may require the concerted effort of a coalition of groups over time. For example, changing admission procedures to health professions schools is of such magnitude that coalitions of pressure groups are needed to bring action. Finally, some women are most adept acting as individuals, whereas others function better in groups. We need both types of social change agents.

Influencing Legislation, Public Policy and Institutional Practices

Groups seeking to improve their situation often look for strategies to influence legislation and policies on the national, state, and local levels. Although the specifics of influencing federal legislators may be different from influencing a hospital board or university department, historically, certain general strategies have been effective. We shall briefly consider some of these strategies.

1. Becoming a Visible Pressure Group

Historically, physical presence has been an effective means of exerting power. Legislators, administrators, and other policy-makers respond to "bodies" converging in their offices and halls and watching their deliberations. Bullough and Ver Steeg[3] point out how effective this has been in passing nurse-practice acts. Others report similar success in getting needed votes in academic senates and administrative offices for women's programs.

2. Developing Inside Contacts

Allies are often found in odd places. Staff personnel in government and health institutions are valuable sources of information. Sisterhood and genuine commitment to shared goals for change can lead secretaries to pass on inside information on upcoming hearings, alert outsiders to meetings called on short notice, and make available drafts of pending legislation or policy. Inside staff can also offer advice on how to write letters or provide expert testimony in a manner likely to be noticed.

3. Developing Reciprocal Relations with Public Figures

Like lobbyists, activists can establish reciprocal relations with public figures for their mutual benefits. By consistently attending hearings, writing letters, and providing documentary evidence to support the desirability of proposed changes, activists can support public figures. Reciprocal relations of this type have emerged between legislators and activists groups seeking change in abortion, childcare, and community clinic services.

Activists are especially able to alert legislators to emerging trends, providing public figures opportunities to be among the first to raise issues and propose innovative solutions to problems. Senator Edward Kennedy's national and regional hearings on health issues reflect the role activists groups can play to influence policy.

Professionals can also become known for offering reliable, expert testimony on the national, state, and local levels. Some gain a reputation for being able to rally support quickly using their personal and professional telephone networks.

4. Writing Letters

Writing statements of concern or recommendations to legislators and other public figures is effective, particularly if the writer is skillful at presenting positions clearly, concisely, and in a form likely to catch the attention of specific persons. Follow-up letters to thank officials for their efforts or to express dissatisfaction are important. Government officials and inside staff emphasize that letters are really taken into account by policy makers.

5. Managing Publicity

Insiders working quietly behind the scene on delicate matters must be careful that their actions do not embarrass institutional officials, particularly in public where the officials would be forced to placate other groups opposed to change agents' proposals. Publicity is best shunned where changes will create enemies for higher level officials.

However, in some situations, judicious use of publicity can bring needed pressure on officials. Developing good working relations with the press and knowing how and when to use these relations is always a delicate matter. Where a good relationship has been established, reporters can be trusted not to use material which will hurt you and will respect the informant's decision of whether the information is to be used as a direct quote or not for attribution. If trust is high, one may suggest that the reporter try to find out something, although the informant may be unwilling to offer the information on herself or himself. Having a reputation for being on good terms with the press may even provide some leverage and power, particularly in situations where others wish to avoid publicity.

6. Forming Coalitions with other Activists Groups

Often different groups may press for legislative change in the same area. Forming coalitions and keeping each other informed on ongoing issues and activities makes both groups and individual members more effective. Currently, two national organizations attempt to keep abreast of pending legislation and policy making in women's health areas--the Women and Health Roundtable, an affiliate of the Federation of Professional Women's Organizations and the National Women's Health Network, a coalition of feminist health rights groups.[4] Both organizations publish frequent newsletters with suggestions on where letters and other support are needed. Women's rights groups, such as NOW (the National Organization of Women) and WEAL (Women's Equity Action League), also have subcommittees on health-related issues and suggested action.

These organizations also serve as communication networks between groups by reporting on current issues and actions different groups are taking. For example, the Women and Health Roundtable recently reported on a study of HSA governing boards and professional staffs and is recommending to HEW Secretary Califano that programs be designed for women on HSA boards. The Roundtable also reported on NARAL (National Abortion Rights Action League) and NOW action on discrimination in abortion and pregnancy disability benefits.[5]

Managing Nonactionable Sex Discrimination

Some of the more subtle and pernicious barriers to women's advancement are not easily rectified by laws or official policies. As Mary Rowe points out, the minutiae of sexism and racism are rarely actionable.[6] The conscious or unconscious slights, treatment as being invisible, harassment, poor service, or personal exploitation are common petty incidents which seem trivial and insignificant. But, taken together, they pose formidable barriers to women. How can these individual incidents of nonactionable sex discrimination be managed and reduced in frequency or impact? How can men and women both be made aware of the seriousness of the minutiae of sex discrimination and be induced to change their behavior?

1. Labeling the Phenomenon

Naming the minutiae of sex discrimination, as Rowe does in describing the "Saturns Rings Phenomenon," may help bring the issue of informal sexism into focus. Rowe suggests that, like the dust and ice in Saturn's rings which partially obscure the planet, the minutiae of sex discrimination forms a barrier obscuring good jobs from minorities and women.[7] Since persons accused of sexist behavior often deny the charge or dismiss the incident as trivial or insignificant, explaining the "Saturns Rings Phenomenon" may be a starting point for showing how many trivial incidents add up to serious discrimination. Such an approach offers an opportunity to "excuse" sexist behavior as unintentional minor slips, while insisting that the behavior should not recur.

2. Acting Swiftly

Nonactionable forms of sex discrimination are often managed best by acting swiftly when they occur. An immediate tactful comment may be a more effective sanction than a formal complaint written long after the fact. The sanctioner is also less open to the accusation of making mountains out of molehills when the response is on the spot and spontaneous. These comments also alert others that even subtly discriminatory remarks do not go unnoticed. One hopes that over time these comments will also have a "Saturn's Rings" effect and make trivial but objectionable remarks less acceptable.

3. Enlisting Support from High-Status Leaders

Explaining the seriousness of sex discrimination to high-level leaders including university presidents, hospital chiefs-of-staff, and department chairs is important. High-level leaders can assist in combatting subtle discrimination through issuing formal statements on the subject and setting a positive personal example. These acts set the tone for lower-level personnel, making sexist behavior less openly acceptable. Affirmative action officials report that having this high-level support is particularly important.

4. Confronting Individuals who Engage in Nonactionable Discrimination

In some situations, group confrontations are effective to combat nonactionable discrimination. Where several women have experienced similar forms of sex discrimination from one individual or work group, this strategy is particularly useful. Such confrontations are less easily managed when only one woman has a complaint, for it becomes one person's word against the other's. When contemplating such confrontations, the power and status differential between the complainants and accused must be taken into account, particularly if the accused has official power over the complainants. For example, it may be inadvisable for junior faculty to complain to the chair about discriminatory hiring practices in a department, whereas tenured faculty might do this without seriously jeopardizing their positions.

5. Seeking Formal Outside Intervention

In some settings, formal channels exist for investigating complaints. Affirmative action departments and committees on the status of women might be encouraged to intervene more often in cases of officially nonactionable discrimination. Although formal sanctions could not be invoked, informal communications through formal channels about complaints would increase awareness of and sensitivity to the minutiae of discrimination. For example, an affirmative action officer's telephone call or personal visit to individuals who reputedly make sexist comments in class could undermine the view that such behavior is fully acceptable.

6. Seeking Informal Intervention from Higher-Status Persons

Higher-status persons sometimes may effectively intervene on the behalf of lower-status persons. For example, faculty may be in a better position than students to make complaints to the administration about reported sexual advances to students from their colleagues. Or, senior faculty can write letters to administrators or for personnel files when they believe that specific junior faculty are being unfairly evaluated because of sex bias. Such letters may help women later to obtain tenure or promotion by providing alternative evaluations and by putting negative evaluations in perspective. Thus, for example, a new departmental chairman might view negative comments about women faculty as less damaging if a senior person has reported that the former chairman not only tolerated but encouraged sexist treatment.

Whenever possible, higher-status persons might be encouraged to advise younger and/or lower-status persons how to deal with problems on their own. This socializes entrants to become self-sufficient and manage their own causes.

Creating Awareness of Sexism and Changing Attitudes

Thus far, consciousness raising has been directed towards increasing women's own awareness of sexism and how it limits options. Little attention has been directed towards encouraging men to understand how women's concerns are important for them either personally or professionally. That is, women have made as little effort to attract men to women's studies courses, conferences, and academic research areas as men have made to seek out women leaders. The key is for women to devise strategies to convince men that it is in their best interest to take seriously women's attempts to move up into positions of leadership and authority. How might this be done?

285

1. Sponsoring Conferences, Workshops, Seminars

Conferences for health workers are effective means of disseminating information on women's roles in the health professions and their special needs as professionals. Typically, however, few men attend conferences on women's issues. Including prominent men on panels and offering workshops specifically addressed to how men can learn to work more effectively with wpmen colleagues, supervisors, subordinates, and patients might attract more male participants. Smaller seminars and workshops might also be offered by outside consultants in health service and training institutions as part of regular personnel development programs.

A difficulty, however, is that women do not want men to patronize them or take over control of public events. In addition, some women are not eager to have men present at all at many functions, for they see the events as opportunities for creating female solidarity and support groups.

2. Disseminating Information on Women's Roles

Research and articles on women's roles in the health professions generally is published in academic journals read almost exclusively by other academics. It is rarely reported in the journals that health professionals or professional educators read. While researchers can be exhorted to publish articles for a health profession, rather than research, audience, the academic reward structure does not encourage such effort. For articles published outside of academic journals do not "count" for tenure and promotion. Furthermore, few academics know how to write well, or at all, for nonacademic audiences.

To disseminate information, established researchers might be encouraged to write such articles as public service activities and get universities to recognize and reward this activity as a public service like serving on community policy boards or as advisors to public agencies. Health professionals might review recent research on women's roles in their fields and write articles themselves. Health professionals might also specifically invite researchers to write and present papers at their conferences and meetings, gatherings which academics rarely know of or would attend on their own.

However, an underlying problem is legitimating research on sex roles and sexism as an area of inquiry. Gaining legitimacy is circular to some degree. Until an area is legitimate, it will receive little attention; yet interest and attention is needed to acquire legitimacy.

3. Assigning Students Material on Women's Roles

Students (both male and female) can be assigned readings analyzing women's roles and sexism. Strategies need to be developed for presenting the material to show to men, in particular, the need for behavioral change.

Moving Women Up Informally

Power and authority are wielded through informal as well as formal channels in the higher circles of the health professions. Policy discussions, recommendations for new research and programs, and suggestions of candidates for important posts all take place informally. Women have difficulty gaining access to these inner circles, for they seem "out of place." They have not attended the prestigious male training institutions, belonged to the all-male clubs, or participated in activities which would prepare them for the wheeling and dealing done at the top. Men and women alike feel uncomfortable when their sex-segregated groups are invaded, and fear a loss of solidarity.[8] What strategies can help women break this barrier?

1. Developing Informal Networks

Men rise into positions of leadership and authority through "old boy" networks. Women are rarely accepted into the inner circles of these networks where power and influence are wielded. Excluded from these informal aids to mobility, women have developed parallel all-female networks. As Daniels points out, these feminist networks provide opportunities to gain inside information and make crucial professional contacts.[9]

While feminist networks are important to maintain to provide women support and socialize them into professions, exclusively participating in all-female networks poses some problems. Men may be suspicious of women who show allegiance to counter systems, and view them as troublemakers or only marginal to the larger profession. Also, to advance beyond the lower rungs of professional life, women need to gain access to the informal male-dominated networks. Participating in these mainstream networks even at the periphery (if not the inner circles) may provide women opportunities to make the contacts they need to move up.

Developing dual networks (or, in the case of ethnic minority women, possibly triple networks) requires a willingness to attend numerous meetings and conferences, serve on committees, and write for several audiences--all time-consuming endeavors. Participating actively in alternative informal networks may also create strains in allegiance and commitment which can be personally draining.

2. Role Modeling and Mentoring

Women in positions of leadership and authority provide visible role models for students and younger women. These women offer both positive and negative examples of personal and professional behavior useful to others in the process of developing professional identities.

In addition to models, women need active assistance from already established women. The extent of involvement of the senior professional can range from simple advising to sponsoring or mentoring.[10] While formal advisors are provided all students, the more intense socialization gained through sponsorship and mentorship is not as readily available. To move women into leadership, sponsorship and mentorship are crucial.

While both Rowe and Haseltine encourage students to seek mentors, there are problems in availability and matching. First, there are relatively few women at high levels to serve as mentors. Such women may have less access to informal power in their fields than male mentors, and consequently be less able to assist younger women. Second, there may be difficulties in establishing mentor relationships where the sex, race, or class backgrounds of mentor and student are different.

Mentors, or potential mentors, have an additional structural problem when mentoring women in general, and specific women who seek their assistance. In fulfilling their responsibilities for recruitment and perpetuation of leaders in the field, mentors make judgments about women's potential and are selective about the time and effort they devote to mentoring. Since their own reputation and judgment are at stake in making recommendations and drawing younger professionals into the inner circles of their fields, they will not be equally available to all who seek their aid.

Women mentors' strain comes from standing in two networks. While they may be committed to sisterhood and advancing opportunities for women, they also hold the standards of excellence of their male colleagues. And they must be careful to maintain those standards to preserve their credibility. Thus, they must carefully pick and choose among students (as does any busy person with limited time) to meet the goals of both networks. Such women are especially vulnerable to being accused of both "letting women down" and "not keeping up standards."

3. Increasing Professional Women's Visibility

Institutionally sponsored programs can make women health professionals more visible and known to colleagues. Inviting women to present papers and lead workshops helps them establish their reputation in the field and offers them opportunities for making professional contacts. Participants at such affairs often wheel and deal and make plans for future research and programs. These events also provide an opportunity for informal exchange of information and widening of women's professional networks.

Other programs such as the National Identification Program for the Advancement of Women in Higher Education Administration that Wilkerson is involved in, provide more formal means of increasing women's visibility.[11] Through a combination of a nationwide search and regional conferences, women are being officially designated as academic administrators deserving of consideration for important posts. Such a program is useful for affirmative action recruitment and hiring and can help dispel the view that "there are no qualified women."

Researching Issues in Women's Leadership and Authority

Research can be a key strategy for social change for it can influence public expectations and provide basic rationales for social programs. The political use of research to encourage social change is not, however, accepted as desirable by all researchers. In fact, some eschew the use of their work for such purposes or argue that science must be value free, uncontaminated by politics or policy.

However, knowledge gained through research is seldom value free. The biases, values, and world view of researchers inevitably make their way into the work. Open recognition of this does not invalidate such research, but rather alerts us to the biases which are inevitable.

Regardless of the values of researchers, findings can often be used by different groups for conflicting purposes. For example, developing psychological measures to predict accurately whether or not individual women are likely to interrupt medical careers for childbearing and rearing (as Lillian Cartwright and Georgina La Russa are doing)[12] can provide valuable information for counseling women and planning training programs to help women meet their dual professional-family commitments. On the other hand, such measures might also be used to "screen out" female medical school applicants on grounds that they will devote less time to their profession than others. While the social use of knowledge is of broad societal concern, researchers committed to social change must be particularly aware of the multiple uses of their endeavors.

We must also learn to use our research more effectively, more innovatively. Government officials point out that legislators and other policy makers certainly will not seek out or read lengthy research reports. Although as researchers we are not trained to do so, we might learn to write more concise reports or executive summaries of major studies. If we want such research to have an impact on policy, we must learn to identify the policy implications of our work and suggest what types of action our research suggests. Waiting for others to come to us, to ask our counsel, will not move us forward.

From the work we have considered in this conference, it is clear that additional basic and applied research on women's roles in the health care system and in the larger society are needed. We also need to evaluate the outcome of programs designed to facilitate women's career development, not only in terms of their consequences for individual women, but for the society at large.

What will our specific research priorities be? Shall we leave it to chance, to the idiosyncratic interest of individual scholars? Might it be better to develop priorities and attempt to influence the allocation of scarce resources? These questions are not easily answered.

Where Do We Go From Here?

As we consider strategies to move women up in the decade to come, we must give serious attention to both structural and social-psychological factors affecting women's assumption of power and authority in the health professions and in the larger society. We need to ask ourselves what effects female mobility have on the larger social system. What larger social and economic factors underlie the resistance or propensity of male-dominated professions and other institutions to change? Are there certain institutional arrangements which enable or hinder women's rise into leadership, and if so, how do we foster the more favorable forms?

We need to examine leaderships styles, the verbal and nonverbal ways in which women and men exert power and authority and grant or deny legitimacy to others' authority. How do class, race, and religion interact, and what are the differential consequences of exerting authority in same-status versus cross-status situations? We also need to know more about what motivates women to pursue high-level positions. What are the psychological factors and structural factors that raise women's aspirations and facilitate their effectiveness?

Our optimism for moving women up, however, must be modulated; we may have reached a plateau in women's rights. Setbacks in abortion rights, the drop-off in women and minority admissions to medical schools, and opposition to affirmative action programs and the Equal Rights Amendment bode ill for the decade to come. Much energy may have to go in to preserving what we have gained rather than moving ahead. For women in health, there is much work to do.

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FOOTNOTES

[1] The ideas and specific examples presented in the final sessions by the following conference participants were especially useful: Tora Kay Bikson, Rue Bucher, Bonnie Bullough, Arlene Daniels, Gladys Handy, Florence Haseltine, Amber Jones, Jean Lipman-Blumen, Nancy Henley, Rachel Kahn-Hut, Jane Mansbridge, Virginia Olesen, Eileen Shapiro, Donna Ver Steeg, Norma Wikler, and Margaret Wilkerson.

[2] For extended discussion of the role of insiders as change-agents, see Freeman, Jo, *The Politics of Women's Liberation: A Case Study of an Emerging Social Movement and Its Relation to the Policy Process*. New York: David McKay Company, Inc., 1975. For detailed analysis of outside strategies for changing the health care system see Ruzek, Sheryl K., *The Women's Health Movement*. New York: Praeger, 1978 (forthcoming).

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[4] The National Women's Health Network, *Network News*, P.O. Box 24192, Washington, D.C. The Women and Health Round Table, *Round Table Report*, Federation of Organizations for Professional Women, 2000 P Street N.W., Suite 403, Washington, D.C., 20036.

[5] *Round Table Report*, No. 3, March 30, 1977.

[6] Rowe, Mary, "The Saturn's Rings Phenomenon: Micro-Inequities and Unequal Opportunity." In this volume.

[7] *Ibid*.

[8] For discussion of difficulties women face attempting to enter male dominated professions, see e.g. Bernard, Jesse, "Historical and Structural Barriers to Occupational Desegregation." In Blaxall, M. and B. Reagan (eds.), *Women and the Workplace: The Implications of Occupational Segregation*. Chicago: University of Chicago Press, 1976.

[9] Daniels, Arlene Kaplan, "Development of Feminist Networks in Health Sciences." In this volume.

[10] Haseltine, Florence, "Why Be a Role Model When You Can Be a Mentor?" and Rowe, Mary, "Go Hire Yourself a Mentor." Both in this volume.

[11] Wilkerson, Margaret B., "A National Program to Advance Women in Higher Education Administration: A Progress Report." In this volume.

[12] Cartwright, Lillian, "Continuity and Noncontinuity in the Careers of a Sample of Young Women Physicians." In this volume.

XI.

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EVALUATION SUMMARY OF
WOMEN'S LEADERSHIP AND AUTHORITY IN THE HEALTH PROFESSIONS CONFERENCE
JUNE 19-22, 1977

Twenty seven evaluations were returned almost unanimously evidencing an outstanding positive response to the Conference. We divided the questions into the four categories: physical arrangements, conference format, conference substance and overall evaluation. The questions were asked in a manner which enabled us to get measurable answers as well as some subjective narrative.

Physical Arrangements

1. The Conference accomodations were:

20 excellent   7 good   0 fair   0 poor

2. The Conference meals were:

18 excellent   7 good   2 fair   0 poor

Conference Format

1. How did you find the working conference format?

22 excellent   4 good   1 fair   0 poor

2. Was having papers to read in advance useful?

24 very useful   1 somewhat useful   1 not useful

3. The time devoted to individual presentations was:

0 too long   22 about right   5 too short

4. The time allocated for discussion was:

0 too long   18 about right   5 too short

5. How could the format have been improved?

Many of the women had no response at all to the question. The most frequent answers were:

- More discussion time	5
- Wished conference was longer	2
- Fewer presentors or panels	2
- Could have been more highly focused	2
- Smaller groups	1
- Received papers earlier	1
- More meeting space	1
- Fewer papers to read (but loved them all)	1

Evaluation Summary

The majority of remaining and additional responses were along the lines of "magnificent job," "incredibly good," and "can't think of improvement."

Conference Substance

1. How interesting and informative were the conference papers?

23 very interesting   2 somewhat interesting   0 not very interesting

2. Did you like having the opportunity to write and read in progress materials?

24 yes   0 no

3. Were the range of topics presented relevant and important issues?

20 very relevant   4 somewhat relevant   1 not very relevant

4. Have you learned anything which you will incorporate in your current or future work?

24 yes   1 no

5. How will the conference affect your current or projected work?

- It has generated new research ideas	13
- I'll draw heavily on the network formed here	5
- It has given me specific ideas of what to look for	3
- Good resources to cite	2
- Clarified my thinking	4
- Learned new information	2
- I found my work to be of more general value and more interesting than I'd realized	1
- New, good materials to share with my students	1
- I'll renew my efforts to act as a mentor	1
- No effect	1

6. Did you get any useful feedback on your own work?

15 yes   6 no

7. Did you make new or renewed professional contacts that will be useful?

22 yes   1 no

Overall Evaluation

1. 24 excellent   0 very good   1 fair   0 poor

2. What aspect of the conference was least satisfactory and how could we have made it more satisfactory?

- More advance homework for the panelists	1
- Papers of a more even quality	1
- Papers too social-psychological should have been a few more structurally oriented papers	1

- Sorry can't think of a thing	1
- It is hard for me to make a comment that would really be able to improve the meeting	1
- Can't think of anything	1

3. The least favorable evaluation gave some worthy and constructive criticism:

"Conference was not focused--title was Women's Leadership and Authority In the Health Professions but most of papers did not address this topic. Many papers dealt with male and female sex roles. Should have had female health professionals, not social scientists. If you were to have all social scientists than change title of conference to "Study of Effects of Socialization Process on Women in Professions."

4. What aspect of the conference was most useful or interesting to you?

- Meeting a wide range of women; enhancing my network	5
- The opportunity for an interchange of ideas with women from different diciplines	4
- The discussion	6
- The diversity	4

5. Additional Comments:

Feedback from the evaluations as well as informal discussion indicated that most of the women felt this was the most, or among the most productive and well planned conferences they'd ever attended. Several confessed that reluctantly they'd agreed to attend, expecting a "typical" conference with little to learn or accomplish. Here are a few comments:

"I would strongly recommend that this conference be done again in a year's time. I would also strongly recommend that you either invite the same participants or a core group of the same participants. In terms of extending the network, I think that you have the opportunity to create a real women-in-health power base with this unusual (and good) combination of excellent researchers, front-line personnel, health professionals, activists and establishment bureaucrats."

"I particularly appreciated the organization by theme and presentation and the sense of accomplishment which came from discussion of future directions and strategies for the future. And I was especially grateful for the smoothness of arrangements and the care and thoughtfulness with which we were indeed ushered through our exit and entry arrangements."

"Best conference I've ever been to."

"This has been one of the most productive conferences I have attended. . . the conference format which had some free unstructured time during the evenings and late afternoons permitted time for discussion of the papers, presentations and related subjects and, I think, contributed to the quality of the next day's discussions. More than one participant said to me that this was one of the few conferences she had not been anxious to leave before it was over, I share that feeling."

"My sincere thanks to all staff for a very rewarding experience. I have learned and been challenged to learn more. I have changed my mind about some issues. I have met many interesting women with whom I anticipate future contact. The Conference has been well planned and the general feeling of euphoria is a testament to careful management. . ."

Summary

The goals of the conference were well met. The final session really showed us that the conference was, in a sense, a beginning because of the new research ideas generated and strategies which took form. Most participants were enthusiastic to be able to make informal contacts and exchange information with each other. This reinforces our premise that such network opportunities are essential for women's personal career development.